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Issuance date: August 28, 1998
Closing date: DECEMBER 4, 1998

Dear Colleague:

I am pleased to announce the FY 1999 PVO Child Survival Program funded by the Bureau for Humanitarian Response, Office of Private and Voluntary Cooperation (BHR/PVC).

Since FY 1985, the Office of Private and Voluntary Cooperation (PVC) has administered the Child Survival Grants Program. This program is competitive and open to all U.S.-based Private and Voluntary Organizations (PVOs) registered with USAID that engage in health care programming as part of their international development efforts. The Program strives to improve the capacity of U.S.-based PVOs and their local partners to carry out effective child survival programs that contribute directly to the USAID objective of improving infant/child health and nutrition and reducing infant, child and maternal mortality rates in the developing countries.

Priorities for the FY 1999 PVO Child Survival Grants Program are for programs that:

- a. Are carried out in countries and/or program sites with high under-five mortality rates and address the major causes of this mortality in the target location. A special emphasis is placed on eligible countries and/or program sites with under-five mortality rates of more than 100 deaths per 1,000 live births. (See list of eligible countries)
- b. Focus on child survival strategies that have a high potential for sustainability, and, given the capability of the applicant and its partners, are technically and logistically deliverable at reasonable cost.
- c. Involve a partnership with local NGOs or other local organizations.
- d. Plan for the financial and institutional sustainability of the program benefits after the end of the grant.
- e. Focus on viable and innovative strategies, methods, or materials for implementing child survival activities that may be used on a wider scale; and
- f. Contribute to BHR/PVC Strategic Objectives and Intermediate Results.

BHR/PVC has continued the new grant categories, Entry and Mentoring, which assist new PVOs to enter the CSGP, and the 50% cost-share requirement for programs in countries where BHR/PVC has previously funded a PVO for two or more cycles, in order to promote long-term financial sustainability.

This year's program continues to place special emphasis on strengthening the capacity of local partner organizations and financial sustainability.

Full details about the program's purpose and scope, as well as the eligibility requirements and the review process, are described in the enclosed Request for Applications (RFA). Applications are due at BHR/PVC by Friday, December 4, 1998.

BHR/PVC looks forward to receiving and reviewing many fine applications in this cycle. I personally look forward to the opportunity to collaborate with you as a partner in this long-standing and highly effective program.

Sincerely,

John P. Grant
Director
Office of Private and Voluntary
Cooperation
Bureau for Humanitarian Response

Enclosures: FY99 RFA and Annexes

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

REQUEST FOR APPLICATIONS (RFA)
(938-99-A-0500-15)

Solicitation No.: M/OP-98-1875

1999
PVO CHILD SURVIVAL GRANTS PROGRAM

APPLICATION SUBMISSION CLOSING DATE: DECEMBER 4, 1998

BUREAU FOR HUMANITARIAN RESPONSE
OFFICE OF PRIVATE AND VOLUNTARY COOPERATION

Statutory Authority: Foreign Assistance Act of 1961, as amended, and
the Federal Grants and Cooperative Agreement Act of 1977, as amended.

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
BHR	Bureau for Humanitarian Response
CA	Cooperative Agreement
CDD	Control of Diarrheal Disease
CHW	Community Health Worker
CS	Child Survival
CSGP	Child Survival Grants Program
CSSP	Child Survival Support Program
DCM	Diarrhea Case Management
DIP	Detailed Implementation Plan
DPT	Diphtheria, Pertussis, and Tetanus
EPI	Expanded Program in Immunization
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IDA	Iron Deficiency Anemia
IMCI	Integrated Management of Childhood Illnesses
INACG	International Nutritional Anemia Consultative Group
IR	Intermediate Result
IVACG	International Vitamin A Consultative Group
JHU	Johns Hopkins University
LAM	Lactation Amenorrhea Method
MOH	Ministry of Health
MNC	Maternal and Newborn Care
NGO	Non-governmental Organization
NICRA	Negotiated Indirect Cost Rate Agreement
OP	Office of Procurement
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PCM	Pneumonia Case Management
PVO	Private Voluntary Organization
PVC	Office of Private and Voluntary Cooperation
RFA	Request for Application
SCM	Standard Case Management
SO	Strategic Objective
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

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A. APPLICATION PREPARATION AND SUBMISSION INSTRUCTIONS

USAID/BHR/PVC is seeking applications for funding from U.S. Private Voluntary Organizations for programs meeting the requirements of this RFA. We are issuing this RFA in anticipation of funds to be made available to BHR/PVC for this purpose. However, while BHR/PVC expects such funding to become available, there can be no assurance that this will be the case and issuance of this RFA does not constitute an award commitment on the part of the U.S. Government. Further, the U.S. Government reserves the right to reject any or all applications received.

To submit an application for funding from the BHR/PVC PVO Child Survival Grants Program, please submit a separate application for each proposed country program. To be considered for the review process, all applications should be submitted on or before the December 4, 1998 with the name and address of the applicant and RFA Number inscribed thereon to:

Mailing Address:	Hand Carried/Courier Service
Address:	
Child Survival Division	Child Survival Division
USAID/BHR/PVC	USAID/BHR/PVC
Room 7.06-087, RRB	Room 7.06-087, Ronald Reagan
Building	
Washington, D.C. 20523-7600	1300 Pennsylvania Ave. NW
	Washington,
D.C. 20004-3002	

To facilitate duplication for review purposes, we ask that applicants submit to Washington, D.C. a version on diskette, WordPerfect 5.1/5.2, an unbound, single-sided original, and two (2) bound, double-sided copies of the application (each with a complete set of attachments). It is the responsibility of the PVO to send one copy of its Child Survival application to the USAID Mission in the country where the activities are being proposed when it submits its application to BHR/PVC. Applications should be received by the USAID Mission no later than December 18, 1998.

Applicants must submit with the original of their application, the Self-Certifications pertaining to compliance with applicable federal and USAID accepted policies for personnel, travel, and procurement systems. If the applicant has not yet completed these certifications, it may obtain a self-certification package from:

Mr. Steve Tashjian, M/OP/PS/OCC
Ronald Reagan Building, Room 7.08-061
1300 Pennsylvania Ave., NW
Washington, D.C., 20004-3002

Phone: 202-712-532; Fax: 202-216-3143

All applications shall be readable and on standard, letter-size paper (8 1/2" x 11"). Applicants are asked to limit the body of their application to 40 pages or less, and all attachments to 25 pages or less. The body of the application includes responses to items E3 through E9 of this guidance. Pages beyond the forty (40) page limit will not be considered in the review process. Please avoid using space to "educate the reader about child survival." The application will be read and evaluated by specialists in child survival and public health.

When formatting your application it is important to consider the application reviewers' ease of reading. Formatting used for this RFA document is an example of what the reviewers would find easy to read. Applicants are strongly encouraged to approximate this formatting. Type face/characters, including those used in tables, must be no smaller than 10 characters per inch (10 cpi) or 12 points. "CPI" is a fixed pitch spacing per inch. Point refers to the measurement of proportional spacing of scaleable fonts. If you have doubts about the font you are using, hold a ruler under a line and count the characters in an inch. Ten CPI is generally 12 points. Please refer to your word processing manual for a complete explanation.

All Attachments and/or Supplementary documents must be in English or with an English translation.

Unnecessarily elaborate brochures, artwork, expensive paper and bindings, and expensive visual and other presentation aids beyond those sufficient to present a complete and effective application in response to this RFA are neither necessary nor wanted.

The preferred method of distribution of USAID procurement information is via the Internet or copied onto a 3.5" floppy disk (WordPerfect 5.1/5.2 format). This RFA can be downloaded from the Agency web site. The Worldwide Web address is <http://www.info.usaid.gov>. Select "Business and Procurement Opportunities" from the home page, then "USAID Procurement." Select "Download Available USAID Solicitations." Receipt of this RFA through the INTERNET must be confirmed by written notification to the office noted above. It is the responsibility of the recipient of this solicitation document to ensure that it has been received from INTERNET in its entirety. USAID bears no responsibility for data errors resulting from transmission or conversion processes. If not downloading from the INTERNET but rather requesting a copy on a 3.5" floppy diskette or hard copy, please provide the blank diskette and self-addressed labels, and send to the address under Article A, Mailing Address.

Any prospective applicant who has a question concerning the contents of the RFA should submit the question in writing to the

Child Survival Division, BHR/PVC (fax (202) 216-3041 or -3039) by October 15, 1998. Any additional information regarding this RFA will be furnished through an amendment to the RFA.

B. BACKGROUND AND OVERVIEW OF THE OFFICE OF PRIVATE AND VOLUNTARY COOPERATION

USAID's Office of Private and Voluntary Cooperation (BHR/PVC) is the focal point for the Agency's partnership with U.S. Private Voluntary Organizations (PVOs) and Cooperative Development Organizations (CDOs). BHR/PVC's competitive grants programs provide direct support to the U.S. PVOs and their local partners to address critical needs in developing countries and emerging democracies. These programs include: Matching Grants, Child Survival Grants, Cooperative Development Grants, Farmer to Farmer Grants, Development Education Grants, and Ocean Freight Reimbursement Grants. BHR/PVC is responsible for registering U.S. PVOs for the Agency, and is a central contact point in USAID for information on PVO capabilities and programs. The Office is also a key actor in the development of Agency policies and procedures that affect these U.S. organizations.

PVC's Strategic Plan

Each USAID operating unit is guided by its own Strategic Plan that in turn contributes to the Agency's sustainable development goals. BHR/PVC's Strategic Plan outlines its program directions and provides a framework for all the grants programs funded and administered by the office. It articulates the specific approaches and performance indicators that will guide the office's work through the year 2002. Given its importance, all prospective applicants are urged to familiarize themselves with PVC's strategic plan prior to preparing their application. It can be accessed through the USAID Homepage at: www.info.usaid.gov. Highlights are provided below.

PVC's Strategic Objective (SO) is to "increase the capability of PVC's PVO partners to achieve sustainable service delivery." This Strategic Objective builds upon PVC's expertise and historical experience working with U.S. PVOs and CDOs, and reflects its primary mission of strengthening the technical and managerial capacity of these partners to successfully contribute to international development. PVC is uniquely positioned within USAID to build institutional capacity. Over the years, PVC's grants have helped many organizations strengthen their institutional capacities and improve their ability to implement programs that USAID and other donors' support.

PVC's Strategic Objective has three distinct elements -- capacity-building, service delivery, and sustainability -- all of which are critical for ensuring the significant impact of the

work of PVOs on international development problems. The Strategic Objective reflects PVC's commitment that improvement in capability will result in tangible improvements in services to people in developing countries and that the benefits of PVO programs will be sustained over the long term.

Achievement of PVC's Strategic Objective will lead to its goal of achieving sustainable development in priority sectors in which USAID is focusing its efforts: Economic Growth; Population and Human Health; Environment; Democracy; Basic Education and Training; and Crisis Avoidance, Mitigation and Relief. PVC's Strategic Plan recognizes that the capacity of PVOs to partner effectively with local organizations will achieve another important outcome: NGO and other local partners strengthened. The Office has incorporated this critical, complementary objective in its plan as a Sub-Goal.

To achieve its Strategic Objective, PVC has identified five sub-objectives, or "Intermediate Results", that cut across all of the grants programs supported by the Office. These focus on five areas that are critical to achieving PVC's strategic objective: improving the operational and technical capability of PVOs; strengthening the partnership between USAID and the PVOs; strengthening partnerships between U.S. PVOs and local NGOs; improving the mobilization of resources by PVOs, and raising public awareness about international development. These are discussed below in more detail under the highlights from this year's results report.

Measuring and Reporting on the Results of PVC's Grants Programs

PVC's competitive grants programs are the main mechanism for PVC to implement its strategy, and therefore, it is critical for PVC to be able to demonstrate solid and convincing results from its grant programs. The office judges its success in achieving the objectives of its Strategic Plan by reporting annually on key performance indicators, related to its strategic objective and intermediate results. The impact, or results achieved by the PVOs in the various grants programs are consolidated by PVC and reported in an annual Results Report. This information is the foundation for the Office budget request and is incorporated into USAID's annual Results Report to Congress.

This is the second year that the Office has consolidated results from PVC funded grants and reported to the Agency on the impact of the PVO activities it supports. This report includes PVC's performance indicators, future year performance targets and results achieved over the last year. Given its importance, PVC's most recent Results Report is attached as Annex G. A careful review of this report will help applicants to address one of the key questions in this year's RFAs -- how your proposed program

will contribute to PVC's strategic objective and intermediate results.

Highlights from this year's Results Report

At the Strategic Objective level, PVC reported the following results in relation to the three key aspects of the Objective:

(1) Capacity building -- There has been a slow but steady improvement in the organizational capacity of our PVO partners as measured by our capacity assessment index -- the Discussion Oriented Organizational Self-Assessment (DOSA). There has also been a 21% membership increase in key PVO networks supported by PVC.

(2) Service Delivery -- Both child survival and microenterprise programs have shown impressive strength. Child survival programs had a substantial upward performance trend in maternal immunization and exclusive breastfeeding, a consistent increase in women's knowledge of when to seek antenatal care and in Tetanus Toxoid coverage. There was a 75% increase in loan volume in microenterprise projects.

(3) Sustainability -- 8% of microenterprise programs have achieved full operational sustainability. However, many PVO programs showed an ongoing decline in the level of local financial contributions to their programs.

PVC reported strong performance in relation to its five key Intermediate Results:

1. Operational and Technical Capacity of U.S. PVOs Improved

Improving the operational and technical capacity of U.S. PVOs directly affects their ability to achieve sustainable service delivery and to transfer this capacity to local NGOs. Results achieved this year include:

- The quality of PVO program plans increased in most of the quality areas rated. While capacity was very strong in use of state-of-the-art technical approaches, both sustainability planning and use of appropriate performance indicators were identified as areas needing improvement; and
- 45% of PVC-funded grants have a systematic approach to monitoring program performance and measuring impact.

2. Strengthened Partnership between USAID and U.S. PVOs

PVC plays a significant role in identifying and addressing issues of importance to the PVO community and strengthening the USAID/PVO partnership, in part through its capacity as Secretariat of the Advisory Committee on Voluntary Foreign Aid (ACVFA). A key result achieved this year was:

- The number of ACVFA recommendations adopted by the Agency increased.

3. Strengthened U.S. PVO and NGO Partnership

This is a key Intermediate Result, which supports PVC's Strategic Objective and contributes directly to the sub-goal of the office, "NGOs and other local partners strengthened." The objective of fostering partnerships between PVOs and NGOs is to bring the unique strengths, experiences and insights of the two types of organizations together in a synergistic way to increase the impact of development assistance and to build and sustain the capacity of local NGOs to promote effective development at the community level. A strong partnership implies, among other things, a sharing of resources and transparency and clarity on roles and responsibilities. Results achieved this year include:

- 75% of the PVOs had formal partnerships with local organizations as compared to 50% last year; and
- An increased percentage of PVOs transferred resources to their local partners, and 61% of these PVOs assisted their NGO partner to leverage resources from external sources.

4. Improved Mobilization of Resources by PVC's PVO Partners

A broad and diversified funding base that avoids over-dependence on any one donor is a critical factor in PVO sustainability. Results achieved this year include:

- The percent of PVOs with a diversified funding based increased.

5. U.S. Public Awareness Raised

Increased understanding and awareness of the benefits of international assistance will lead to increased public support of PVO programs and a more diversified funding base. Public support for PVOs reflects a public-private partnership that is nurtured by informing and educating the public about development needs, programs and the role that PVOs and CDOs play in delivering important development services. A key result achieved this year was:

- 39% of the PVOs are currently measuring change in public awareness of development assistance, as compared to 17% last year.

Strategic Priorities for 1999

Given the importance of PVO grants to the achievement of the objectives of PVC's Strategic Plan, all applicants this year are asked to give particular attention to describing how their proposed program will contribute to PVC's strategic objective and five Intermediate Results.

Based on PVC's experience over the last year and the analysis presented in PVC's Results Report, this year's RFA also places particular emphasis on the following priority areas:

Capacity building for NGOs and other local organizations: Strong emphasis is placed on strengthening the capacity of NGOs and other local partners through the grants programs, and on establishing clear capacity building objectives. Applicants to the Matching Grants and Child Survival Program are also asked what skills they need to develop in order to carry out capacity building activities more effectively, and how the proposed program will help them do so. Successful applicants in these two programs are expected to sign a formal agreement with their local partner(s) after the grant is awarded and to develop a plan to measure changes in their partner's organizational capacity.

Sustainability: Strong emphasis is placed on promoting the long term sustainability of program related activities or benefits. PVC encourages all applicants to be as specific as possible in defining their approach to sustainability, in articulating a clear sustainability plan, and in defining how sustainability will be measured. Particular emphasis will be placed this year on financial sustainability, including creative approaches to resource mobilization.

Managing for Results and Performance Reporting: Strong emphasis is placed on well designed programs with a concise, manageable set of objectives that accurately reflect the results and impact that the program seeks to achieve, and a clear set of indicators to measure program performance. All applicants are urged to develop a clear and complete monitoring and evaluation plan for their proposed program.

In addition to the priorities outlined above, PVC will be looking closely at the proposed costs of the programs in relation to the planned activities to be carried out and projected benefits. Applicants are encouraged to carefully consider innovative ways to achieve cost savings or economies of scale in their programs.

Finally, PVC is encouraging innovative ways to involve new PVOs and to multiply the capacity building effects of its programs. In the Matching Grants and Child Survival Grant Programs, PVC strongly encourages experienced PVOs that have successfully completed at least one grant with PVC to partner with another U.S. PVO with international development experience but no prior grant experience with PVC. The Farmer-to-Farmer program encourages experienced implementors to partner with other eligible organizations with appropriate skills that are interested in developing a volunteer program in international development.

Copies of PVC's Strategic Plan may be downloaded from the USAID homepage at www.info.usaid.gov.

C. THE PVO Child Survival Grants Program (CSGP)

C.1. Program Goals and Objectives

The PVO Child Survival Grants Program (CSGP) is a competitive grants program funded and administered by the Bureau for Humanitarian Response (BHR), Office of Private and Voluntary Cooperation (PVC). The program is open to all U.S.-based Private and Voluntary Organizations (PVOs), registered with USAID, that engage in community health care programming as part of their international development efforts.

The objective of the CSGP is to improve the capacity of U.S.-based PVOs, and their local partners, to carry out effective child survival programs that contribute directly to the USAID objective of "infant and child health and nutrition improved and infant and child mortality reduced".

Consistent with PVC's Strategic Objective described in Section B, the PVO CSGP focuses on strengthening the ability and the capacity of PVO staff to design, manage and evaluate child survival activities, to fund and manage a child survival and health portfolio, to engage in long-term partnerships with NGOs, and to disseminate information on PVOs' comparative advantages in child survival and health activities. This program supports institutional strengthening of U.S. PVO field and headquarters operations, and their local partners, enhancing their capacity to reduce infant, child, and maternal mortality and morbidity.

This strengthened ability and capacity of the U.S. PVOs contributes to PVC's Strategic Objective (SO). More over, experience with this program has shown a contribution to all of PVC's Intermediate Results. The partnerships between USAID and the U.S. PVOs, both with PVC and with the USAID field missions, have become more collaborative. While this program was developed to strengthen the skills of US PVOs, all programs require partnering with local organizations, thus the CSGP expects that the US PVOs will transfer technical and managerial skills to their partner organizations. Through this program, the partnerships between the U.S. PVOs and their local counterparts are clearly defined and more productive. The CSGP requires sharing resources to reach a common goal. The PVOs participating in this program have contributed significantly to its success over the years, with both financial and human resources. The rigorous requirements of this program have enabled our partners to document their successes and more vividly convey to their supporters the work they have accomplished in developing countries.

In striving to meet its strategic objective, BHR/PVC supports specific activities for PVOs receiving funding under the CSGP.

PVOs receive individualized technical assistance in program design and implementation, and periodic state-of-the-art information on child survival interventions. They are invited to take part in training activities focusing on measuring, documenting and disseminating results and specialized workshops and conferences for personnel at the country, regional and headquarters level. BHR/PVC also uses the participatory analysis of the Detailed Implementation Plan (DIP) as a learning experience.

C.2. Program Priorities

BHR/PVC strives to invest USAID resources in well designed, technically sound, cost-effective programs that focus on activities and strategies through which programs may expect to make the greatest impact in sustainable reductions in mortality of children under five. Priorities for the FY 1999 PVO Child Survival Grants Program are for programs that:

- a. Are carried out in countries and/or program sites with high under-five mortality rates. A special emphasis is placed on eligible countries and/or program sites with under-5 mortality rates of more than 100 deaths per 1,000 live births. (See Section C.4, Eligible Countries)
- b. Focus on child survival strategies that have a high potential for sustainability and, given the capability of the applicant and its partners, are technically and logistically deliverable at reasonable costs.
- c. Involve a formal partnership with a local NGO or other local organization.
- d. Plan for the financial, and institutional sustainability of the program benefits after the end of the grant.
- e. Focus on viable and innovative strategies, methods, or materials for implementing child survival activities that may be used by others, or are applicable on a wider scale; and
- f. Contribute to the BHR/PVC Strategic Objective and Intermediate Results.

Child survival interventions¹ currently supported through the CSGP include:

¹ This program uses the term "interventions" as defined in the Disease Control Priorities in Developing Countries, sponsored by the World Bank: to denote actions taken by or for individuals [modified in this program to include communities] to reduce the risk, duration, or severity of an adverse health condition.

- ◆ Immunization;
 - ◆ Nutrition, including Vitamin A and other micronutrient promotion or supplementation;
 - ◆ Breastfeeding;
 - ◆ Control of diarrheal disease;
 - ◆ Pneumonia case management;
 - ◆ Control of malaria;
 - ◆ Maternal and newborn care;
 - ◆ Child spacing; and
 - ◆ Prevention of Sexually Transmitted Infection and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), where these have an impact on child mortality.
- Other infectious disease activities may be appropriate in certain sites, where these have an impact on child mortality.

C.3. Eligibility Requirements

All applications will be reviewed against the following eligibility requirements.

- a. Organizational Criteria - To be eligible for funding under the BHR/PVC Child Survival Grants Program, an organization must:
 1. Be a U.S.-based PVO, currently registered with USAID at the time of application submission;
 2. Receive at least 20% of its total annual financial support for its international programs from non-U.S. government sources (or fall within Congressionally-mandated guidelines);
 3. Contribute, from its non-U.S. Government resources, at least 25% of the total cost of the proposed program (for PVOs proposing a program in a country where they have been funded for two or more funding cycles, including non-consecutive cycles, a 50% cost-share is required);²
 4. Have experience implementing community health related programs in developing countries; and
 5. Have a formal presence in the country where the child survival program is proposed, documented by a signed agreement with the host government included in the application. Previous health program experience in the target country is not required.

² The definition of cost-sharing is found in USAID 22 CFR Part 226.23. Additional guidance is provided in the Budget Guidance section of this RFA.

b. Program Criteria - Proposed programs must meet the following criteria to be considered for funding:

1. Be proposed in a country or countries:
 - On the eligible country list;
 - Where the PVO does not already have an active BHR/PVC-funded PVO Child Survival Cooperative Agreement that has been awarded through the annual competitive process, and that follows this program's requirements. A PVO may not have more than one USAID BHR/PVC CSGP in a country at any one time³;
2. Be consistent with USAID's country specific program priorities in the population and health sector, document consultation with the USAID Mission, and have the USAID Mission's approval for the proposed program (See Section D.2, Review Process);
3. Be consistent with the national policies in child survival in the targeted country;
4. Involve a formal partnership with a local NGO or other local organization. BHR/PVC requires PVOs to form partnerships with local non-governmental organizations (NGOs), community-based groups, local health authorities, and/or other U.S.-based PVOs. All applications must be prepared in collaboration with all pertinent partners in the proposed program site; and
5. Assign at least one public health professional at the PVO's U.S. headquarters to be responsible for backstopping CSGP activities, and one full-time staff person, with substantial experience in implementing community health or child survival programs, at the proposed field site.

³ Exception: In the case of a Mentoring Partnership, where the new organization is the recipient, the sub-recipient PVO remains eligible for CSGP funding in a separate program in the same country.

C.4. Eligible Countries

The following countries have been proposed by the USAID field offices in the country. The end-of-century goals, agreed to by almost all the world's governments following the 1990 World Summit for Children, specify a one-third reduction in 1990 under-five death rates (or to 70 per 1,000 live births, whichever is less). Therefore, the BHR/PVC PVO Child Survival Grants Program will include in selection criteria, additional points for program sites with under-five mortality rates over 70/1,000 and over 100/1,000 (please refer to section D for more specificity). BHR/PVC recognizes that high mortality areas do remain within some lower mortality countries. PVOs proposing a program in one of the lower mortality countries shall document the need of the targeted population.

Under-5 Mortality Rate*	AFRICA	ASIA, NEAR EAST and CENTRAL ASIA	LATIN AMERICA & THE CARIBBEAN
>100/1,000 live births	Angola Congo, Democratic Republic of ** Ethiopia Ghana Guinea Madagascar Malawi Mali Mozambique Nigeria Rwanda Senegal (not confirmed) Tanzania Uganda Zambia West & Central Africa Region *** (Burkina Faso, Cameroon, Togo, and Ivory Coast)	Bangladesh Cambodia India Nepal Yemen	Bolivia Haiti
70-100/ 1,000	Kenya	Egypt (not confirmed) Indonesia Morocco Tajikistan	

50- 69/1,000	South Africa	Uzbekistan	Guatemala Nicaragua Peru
< 50/1,000		Republic of Georgia Philippines	Ecuador El Salvador Honduras

- * The State of the World's Children, 1998, UNICEF.
- ** Democratic Republic of Congo (DROC): Final decisions would require clarification and stabilization of the present situation and agreement by USAID Mission.
- *** West and Central Africa (WCA) Region: PVOs proposing for WCA must consult with those individual on the contact list for guidance on priority interventions. The programs proposed must have regional relevance, no reliance on a US mission, partnership with local organizations and other US and international PVOs to the extent possible, and diversified funding sources for the proposed activity.

C.5. Award Categories

USAID/BHR/PVC is seeking applications for four categories of funding: Entry, New, Follow-on, and Mentoring Partnership programs. All categories are competitive, with proposed programs only competing against others in the same category. PVOs may apply for funding for programs in more than one category. However, USAID will not award concurrent Cooperative Agreements to a PVO under both the Entry Program, and Mentoring or New Program categories.

Owing to limited resources, BHR/PVC will support funding of no more than three Child Survival Cooperative Agreements to any one PVO.

a. Entry Programs (2 years, up to \$400,000.)

BHR/PVC is actively seeking to develop the abilities of new PVO partners to plan and implement successful child survival programs in developing countries. BHR/PVC will consider applications from PVOs that have never received a competitively awarded BHR/PVC-funded PVO Child Survival Cooperative Agreement that follows this program's procedure, but that do have some experience in implementing community health programs in developing countries.

During the first year of the two-year agreement period, PVO recipients will complete an in-depth assessment and analysis of the current health situation in the proposed area, establish strong partnerships with local counterparts, jointly design a

four-year program for the same site, and initiate a limited set of activities.

The analysis should include the current state of the health infrastructure, the current health status of the beneficiary population, the knowledge, practices, and beliefs of the target population, and all other information that would help the PVO develop a child survival program for the proposed site. Upon completion of the analysis, Entry Program recipients that intend to continue with the CSGP will collaborate with appropriate local partners to design a four-year, program using the DIP (Development Implementation Plan) guidelines, and submit the DIP by December 31, 2000, as an application for a four-year program for that site. During the second year of the Entry Program, the PVO and its partners will initiate a limited set of activities that could be scaled up.

The CSGP will be available to assist the PVO during the life of the Entry Agreement with specified technical assistance and training.

Each two-year Cooperative Agreement will be awarded for up to \$400,000.

b. New Programs (4 years, up to \$1,000,000.)

New Programs are four-year programs in an eligible country, in a site where the PVO has not implemented a BHR/PVC-funded PVO Child Survival program, awarded through the annual competitive process, which follows this program's requirements.

Applications for this award category are welcomed from ALL interested registered U.S. PVOs. PVO's may apply for New Programs individually or jointly with other PVOs. BHR/PVC will support up to \$1,000,000 for each new program. A single award will be made to one recipient with any partner PVOs as subrecipients.

c. Follow-on Programs (4 years, up to \$1,000,000.)

Follow-on Programs are those proposed to further develop an existing program where the PVO has implemented a BHR/PVC-funded PVO Child Survival program, awarded through the annual competitive process, that follows this program's requirements. PVOs with currently funded Child Survival programs scheduled to end in FY 1999 may apply for funding for follow-on programs. However, the CSGP can not support amendments to existing awards or follow-on awards for the same activity beyond 10 years of the original award date.

BHR/PVC will support up to \$1,000,000 each for a follow-on program. Applications for all follow-on programs must

demonstrate more in-depth knowledge of the site, greater documented need and progress and include a clear plan for sustainability and transition to other funding. Please note the weighting of the Evaluation Criteria for Follow-on Programs, in Section D of this RFA.

In order to demonstrate progress towards long term financial sustainability, applications for new and follow-on programs, in a country where BHR/PVC has funded a PVO for two or more funding cycles, require a cost-share of 50% of the total program costs. (See Section E.2.b, Cost Share.) Note additional criteria in Section E.7.

d. Mentoring Partnerships Programs (4 years, up to \$1,500,000.)

Mentoring Partnerships are innovative partnership programs between U.S. PVOs that have successfully completed at least one BHR/PVC PVO Child Survival Cooperative Agreement, and other U.S. PVOs with international health and development experience that have not implemented a competitively awarded BHR/PVC-funded PVO Child Survival program following this program's procedures. Based on the positive experience to date for the institutional capacity building and technical accomplishments of these programs, BHR/PVC encourages PVOs to consider developing this kind of partnership.

Under this funding category, USAID will support up to \$1,500,000 for each successful application. A single award will be made to one recipient, which may be either the mentor or mentored organization, with the partner as a sub-recipient. The application should propose the structure that the partner organizations have determined meets their respective needs. At least one of the organizations must demonstrate a current, active presence in the target country.

This category of funding is intended to encourage PVOs with less experience in community-based child survival programs to engage in these activities, and to develop the organizational development and technical skills of the mentor. To help PVOs contact others that might be interested in a partnership attached is a list of all organizations requesting this RFA as of date of issue. (See Annex F, Organizations Requesting RFA.) In addition, a list is provided of past and current CS GP recipients meeting the requirements of a Mentor. (See Annex G, Current and Past CS GP Recipients.)

C.6. Program Restrictions

The CS GP does not support, with USAID Child Survival funds, the following types of activities: income generation, literacy

training, water and sanitation, or activities focused only on adolescents. If the PVO demonstrates that these activities are critical to achieve the program objectives, it may include them under its cost-share. (See Section E.2.b., Cost Share.)

Programs that are beyond the scope of the CSGP and will not be reviewed for funding include those whose primary purpose is: research; equipping hospitals, orphanages or other residential facilities; curative care in hospitals; construction; manufacturing of pharmaceuticals, bednets, or other health aids; evacuation of children to the U.S. for medical treatment; emergency relief activities; or adoptions.

C.7. Requirements for Funded Programs

USAID will award a separate cooperative agreement for each selected country program that includes:

- a. a baseline and a final assessment of the PVO's organizational capacity at headquarters and in-country, and assist local partners to do a baseline and final self-assessment of their organizational capacity;
- b. a baseline assessment of the target population to refine program design, and a final assessment to measure program achievements and performance;
- c. a life-of-program (LOP) work plan, called a Detailed Implementation Plan (DIP), submitted within months⁴ of the program start date, following guidance from USAID (See Annex D.2, Sample Guidelines for Preparation of Detailed Implementation Plan (DIP)) (These guidelines are updated for new CSGP recipients); and
- d. evaluations and submit annual reports, following guidelines provided by BHR/PVC.

The awards made pursuant to this RFA will be subject to the requirements of 22 CFR Part 226 "Administration of Assistance Awards to U.S. Non-Governmental Organizations," and the applicable Standard Provisions for U.S., Non-Governmental Grantees. The standard provisions and 22 CFR Part 226 are available on the USAID website, <http://www.info.usaid.gov>.

Prior to any award decision, the Agreements Officer may request a pre-award survey of the applicant organization(s) to assess

4 Entry Programs will submit a DIP approximately 15 months after the award.

financial management capabilities and to confirm all factors of eligibility for this program.

C.8. Substantial Involvement

Cooperative Agreements are conditional gifts that have substantial involvement of USAID in the implementation of the program. BHR/PVC will be substantially involved during the period of the cooperative agreement. Specifically, the CSGP Cognizant Technical Officer (CTO) will provide:

- a. Approval of the Detailed Implementation Plan (DIP), submitted to USAID/BHR/PVC within six months of the award, and any subsequent revisions.⁵ PVC staff and other technical specialists will review the DIP and meet with the PVO to discuss strengths and weaknesses. Substantial changes, resulting in any revisions to specific activities, locations, beneficiary population, international training costs, international travel, indirect cost elements, or the procurement plan, may require a modification to the cooperative agreement by the Agreement Officer.
- b. Approval of key personnel and any subsequent changes in the positions during the life of the award. The PVO is required to request the approval of the USAID Cognizant Technical Officer for the following personnel: Headquarters Technical Backstop, Field Program Manager, and Evaluation Team Leaders.
- c. USAID involvement in monitoring progress toward the achievement of program objectives during the Cooperative Agreement, include written guidelines for contents of annual reports and midterm and final evaluations in accordance with ADS 303.5.11.a.3.

D. EVALUATION CRITERIA AND REVIEW PROCESS

D.1. Evaluation Criteria

Evaluation Criteria	Maximum Points for CA Type
(2) Proposed Budget - appropriate use of USAID funds - appropriate use of Match/Cost Sharing funds - budget reflects local partnering	Entry: 10 New: 10 Follow-on: 10 Mentoring: 10

⁵ Entry Programs will submit a DIP 15 months after the award.

(4) Description of Organization(s) - application's fit with PVO strategic plan - strategy to apply lessons learned - valid rationale for expanding into CS (new PVOs) - previous PHC experience - identification of challenges & plans for addressing them - status/agreements/relationships in country - personnel: linkages, qualifications, % time - fit of this application to others - agreement & roles of PVOs (Mentoring only)	Entry: 20 New: 10 Follow-on: 5 Mentoring: 15
(5a) Program Analytical Basis - high mortality country and/or program site - site selection criteria / process - analytical basis & rationale for proposed approaches, interventions, & strategies - fit with other donor programs - sound reason for 3rd cycle funding - consistency with Mission and government plans - if applicable, builds on previous in-country experience	Entry: 10 New: 10 Follow-on: 10 Mentoring: 10
(5b) Program Design - results oriented objectives and appropriate indicators - appropriateness & technical soundness of overall design, strategies, collaboration - programs relation to health activities/facilities - inclusion of new methods, strategies, materials	Entry: 10 New: 10 Follow-on: 10 Mentoring: 10
(5c) Child Survival Interventions - realistic objectives, intervention specific indicators, target groups - appropriate strategies, methods, activities - essential elements addressed for each intervention - appropriate integration with existing activities	Entry: 5 New: 10 Follow-on: 5 Mentoring: 5
(5d) Management Plan - strong management structure - adequate HQ plan for monitoring field - staff qualifications in relation to responsibilities - staff responsibilities in relation to # and types of activities - roles of & support to committees & groups - sensible rationale for working with workers & committees - feasible & adequate training plans & assessment of training effectiveness - plan for sustaining volunteer participation	Entry: 5 New: 5 Follow-on: 5 Mentoring: 10

(5e) Work Plan - feasible work plan for LOP - feasible action plan for first year	Entry: 5 New: 5 Follow-on: 5 Mentoring: 5
(5f) Performance Monitoring and Evaluation - program objectives, indicators and plans to measure program achievements & impact - appropriate strategies, methods, & tools proposed to monitor performance, quality and coverage - realistic plans for assessments, surveys and studies	Entry: 20 New: 10 Follow-on: 5 Mentoring: 10
(6) Partnerships and Capacity Building - adequate plans to build strong partnerships with NGOs and local government - verifiable support from proposed partners - plans for capacity building of local partners	Entry: 5 New: 10 Follow-on: 15 Mentoring: 10
(7) Sustainability - realistic definition and plans - identification of resource flow needs; community contribution, cost-recovery or other funding sources - realistic plan to measure change in technical, organizational and/or financial sustainability - cost-effectiveness - realistic devolution strategies for 3rd cycle applicants	Entry: 5 New: 10 Follow-on: 15 Mentoring: 5
(8) Past Performance (if applicable) - past adherence to the terms & conditions of previous awards, both technically and administratively - performance documented in past evaluations - how recent recommendations were addressed	New: 5 Follow-on: 10 Mentoring: 5
(9) BHR/PVC Strategic Plan - contribution to PVC intermediate results & strategic objective - PVO conveyance of results to public	All Applications: 5
Total score converted to percent of maximum	Maximum: 100%

D.2. Review Process

All applications received in accordance with submission instructions cited on the cover page, which meet the eligibility and program requirements, and conform to the application instructions, will be reviewed by a panel of USAID reviewers in strict conformity with the evaluation criteria set forth above. This team will consist of appropriate staff from BHR/PVC/CS, USAID Regional Bureaus, and other USAID offices with related interests and international public health expertise. BHR/PVC will distribute copies of each application to all reviewers, except USAID Missions. Applicants are responsible for providing a copy of the application to the relevant USAID Mission.

USAID Missions will review applications and send their review and comments directly to BHR/PVC. Their review will be a critical consideration in funding decisions. To ensure that proposed programs adequately support achievement of USAID Mission objectives, we strongly urge that applicants discuss their ideas and planned programs with the USAID designated as the contact person (in Annex A), in the targeted country before preparation and/or submission of an application. The PVO should include evidence of this consultation in the Program Summary of the funding application.

The budget narrative of all applications under consideration for award will be reviewed for what are necessary and reasonable costs to support the program.

Upon completion of its initial review of applications, BHR/PVC may, as it deems necessary and appropriate, conduct written and/or oral discussions with those applicants whose applications remain in the competitive range. The decision to conduct such discussions should not be considered a reflection of a final decision about which organizations will receive an award, but rather would be part of the evaluation process.

The review process of the CSGP applications will take approximately two to three months, after which BHR/PVC will prepare a recommendation for approval. The USAID Office of Procurement will negotiate with those PVOs that presented recommended programs, and make awards before September 30, 1999. USAID however, reserves the right to fund any or none of the applications submitted.

D.3. Negotiation and Award

Authority to Obligate the Government -The Agreement Officer is the only individual who may legally commit the Government to the expenditure of public funds. No costs chargeable to the proposed Cooperative Agreement may be incurred before receipt of either a fully executed Cooperative Agreement or a specific, written authorization from the Agreement Officer. If recommended for an award, it is the responsibility of the Agreement Officer to make a responsibility determination regarding your organization. Budget negotiations will be

conducted using OMB Circular 22 CFR 226 and other USAID Guidance that may apply. These negotiations will entail a breakdown of each line item, and reduce to writing all understandings between USAID and the Recipient. The Agreement Officer may request from prospective recipients additional information regarding the budget figures. The final Cooperative Agreement should be made available to the key program personnel.

E. APPLICATION GUIDELINES

Applicants are encouraged to respond to the corresponding sections of the application guidelines below, ensuring that all review criteria are addressed. All annexes should be clearly marked and listed in the table of contents.

E.1. Standard Form 424

Standard Form 424 is the standard form used by applicants as the required face sheet for applications submitted for Federal assistance. Detailed instructions for completing these forms for this program are included in Annex B.

E.2. Budget and Budget Narrative

Standard Form 424A is the form used by applicants for presenting overall budget information. Please refer to Annex B for detailed instructions.

The budget narrative should follow the SF424 and 424A and should fully explain the line item costs for both the federal (USAID) and non-federal (PVO cost-share) funded portions of the budget so that the Cognizant Technical Officer and the Agreement Officer can easily verify your cost based on the calculations shown in the narrative.

The 424A contains 11 Object Class Categories, including the Total. Recipient costs proposed for Training and Sub-grants must be included in the "Other" Object Class category. The costs proposed for Training and Sub-grants must be itemized in the budget narrative explanation of the Object Class Categories so that they may be negotiated and included in the appropriate Cost Elements in the Cooperative Agreement Budget.⁶

a. Headquarters Costs

⁶ Note: Cooperative Agreement Budget: The budget in the award document will be based on the 424A budget and budget narrative submitted by the PVO, and will normally have only four cost elements. The budget will be set up as follows:

<u>Cost Element</u>	<u>Amount</u>
(1) Program (or output)*	-
(2) Training	-
(3) Procurement	-
(4) Indirect Costs (overhead)	-
Total	-

(1) Program: If the Recipient's application has more than one output or program, each output/program would be listed separately. Ordinarily, each instrument supports only one output/objective. Sub-grants may be included in Line Item 1.
 (2) Training: Participant training may be included in Line Item 2 of the award.
 (3) Procurement: The Procurement cost element includes anything the Recipient has to contract out for such as consultant services, subcontracts (NOT sub-grants), supplies, equipment, evaluation costs that are subcontracted, etc.
 Each Object Class Category (cost element) listed in Block 6 of the SF424A has a notation next to it which indicates the budget cost element into which it will normally fall. [For example: Personnel (1) - which shows that Object Class Category 6a. Personnel would be in the "Program" cost element].

For all program categories, PVOs should include budget detail separately for the headquarters and for the field program. Up to 15 percent (15%) of the proposed direct costs of a budget may be allocated to the PVO's U.S. Headquarters cost (or JOINT headquarters in the applications for mentoring partnerships) for support to the field program and for improving Child Survival technical and operational capabilities of US PVOs. Link these costs to the description of capacity building in section E.4, Organization. This amount may be exceeded (up to a total of 20% of the proposed direct costs) if the application clearly shows how any additional funds will improve the PVO's institutional capacity for child survival programming. This does not duplicate established indirect cost rates.

b. Cost-Share

The Recipient agrees to expend an amount not less than 25% of total program cost as required in Section C.3.a.3. The cost sharing contribution will directly contribute to achievement of program objectives, and meet all other criteria set out in 22 CFR 226, Section 226.23. All criteria must be met and discussed in the budget narrative.

The CS GP does not accept support from host country partners as the only or majority of the PVO's cost share. The purpose of the cost share is to demonstrate program ownership and commitment of the PVO. Priority will be given to applications that demonstrate this organizational backing of the proposed program.

c. Restricted Goods

BHR/PVC will not authorize the use of USAID funding for:

- agricultural commodities;
- motor vehicles,
- pharmaceuticals;
- pesticides;
- used equipment.
- U.S. Government-owned excess property, or
- fertilizer.

BHR/PVC does NOT seek waivers for the purchase of non-U.S. motor vehicles, pharmaceuticals, used equipment, seeds or pesticides. The applicant should consider funding such commodities with the non-federal portion of the budget.

The Recipient is expected to use its own private cost-share-matching funds for all procurement of nonexpendable property estimated at over \$5000 per unit and for non-U.S. procurements.

d. Procurement Plan

For all grant categories include a procurement plan. Read carefully the guidance on Equipment, Supplies, and Other, including the sections on restricted goods, in Annex B, Sample Standard Form 424.

SPECIAL REQUEST

USAID/BHR/PVC may have the opportunity to receive supplemental funding for vitamin A and other micronutrients, HIV/AIDS and/or polio/immunization. To the extent possible, please estimate the overall cost of these interventions, if appropriate, for your program. This will position PVC to request these funds.

E.3. Executive Summary (2 pages -- not counted towards 40 page limit)

The Executive Summary is used by BHR/PVC throughout the BHR/PVC program administration to provide a brief description of the Child Survival programs to decision makers, Congress, public inquiries, press, etc. We use the Executive Summary to pull together one informative paragraph, and want this to be the paragraph that the PVO believes best represents its program.

There is no prescribed format for the Program Summary, however, it should briefly describe the proposed program, including: program location; estimated under five mortality rate in the program area; goals and expected impact of the program; estimated numbers of potential beneficiaries; program interventions and strategies; how the local partners participated in the development of the application and will contribute to program implementation; how the program will enhance the PVO's, local partner's and collaborating agency's child survival programming capacity; identification of the local partners and collaborating organizations; and capacity building and sustainability strategies.

Please identify the grant category, and include the names of all authors of the application. Include the name and position of the local USAID Mission representative with whom the proposed program has been discussed.

E.4. The Organization (1-2 pages)

(Under the Mentoring category please provide this information for both U.S. PVO partners.)

- ◆ Briefly describe the U.S. PVO applicant, such as its general purpose, annual budget, major sectors of involvement, and methods of operation;

- ◆ Briefly describe how the application(s) fits into the PVO's overall strategic plan, and how the organization will apply lessons learned from participation in this program to its other Child Survival/Primary Health Care programs/activities in developing countries; or, if child survival is a new technical area, the rationale for expanding into this new area;
- ◆ Briefly describe:
 - a) The organization's experience in implementing, monitoring, and evaluating community-level primary health care/child survival programs; and
 - b) The organization's experience and methodology for backstopping and transferring to its partners its technical and managerial skills;
 - c) Areas or capacities that require strengthening, including new skills required for effectively building the capacity of local partners.
- ◆ In view of the preceding statements regarding the organization, describe the challenges faced by your organization with respect to this proposed program that will require particular attention, and describe how you intend to monitor and address these challenges.
- ◆ Describe and document the organization's operations in the country proposed, and current agreements and working relationships with the proposed host country government and other organizations;
- ◆ Provide an organizational chart that clearly delineates the key personnel responsible for technically backstopping this program in the PVO's US headquarters office and in-country office, how they fit into the overall organization, and the linkages between headquarters, regional office (if applicable), and/or field program personnel.
- ◆ Provide information on the U.S. based key personnel including:
 - a) resumes, or position descriptions if personnel are not yet hired;
 - b) the percentage of time to be devoted to this program;
 - c) percentage of time proposed for other USAID-funded child survival and/or health grants programs for which they are responsible;
- ◆ If the PVO is submitting more than one application, discuss how the activities in this application relate to the other applications;
- ◆ For Mentoring Partnerships, provide, in an annex, a draft Agreement between the two organizations applying for this grant category, which they will sign before an award is made. Include the defined roles, responsibilities and accountability of each partner organization.

- ◆ Please note the requirement to submit the Self Certification Package, Section A. of this RFA.

E.5. Proposed Program Description

a. Analytical Basis for Proposed Program (1-2 pages)

- ◆ This section should provide a thorough rationale for your choice of interventions and strategies. Applicants should avoid explaining the global magnitude, severity of infant and child mortality or the importance of Child Survival interventions. Address the proposed program site. If your PVO, or the local partner, has implemented primary health programs in this country, discuss this experience and describe how the proposed program builds on the in-country experience.
- ◆ Briefly describe the location of the proposed program (a map with scale is appreciated), the estimated total population and number of children under five years of age living in the program site (and identify the sources for the data on the site's population), and socioeconomic characteristics of the population (such as economy, religion, status of women, ethnic groups, literacy, etc.).
- ◆ Briefly describe the levels and major causes of under-five mortality in the country, and (if available) in the proposed program area, and (if maternal mortality is to be addressed by the proposed program) estimated levels and causes of maternal mortality. (Include the sources of all mortality data.)
- ◆ Briefly describe the existing health and child survival related programs, facilities, and activities in the program area (including those of your PVO, the MOH, NGOs, and private and traditional health providers). Discuss the strengths and weaknesses of current services, and opportunities for local collaboration and support between your proposed program and these other organizations and services.
- ◆ Describe the process you used for selecting the site and designing the child survival program, including organizations consulted in-country. Discuss the reasons for selecting the country and site.
- ◆ Applicants applying for funding for a 3rd cycle: Explain why the country, the site, and the program are a high priority for continuing assistance under this program. The PVO must indicate how the nature of the program has changed, as well

as changes in the intervention strategy, other donor activities, and the capability of local organizations.

- ◆ Describe how the proposed program is consistent with the USAID Mission's strategic objectives (for the country in which the program is proposed). Describe the policies of the national government that relate to child survival, and how the proposed program is consistent with these policies. (note requirement in Section C.3.b.2.)
- b. Program Design (No page limitation apart from overall limitations for document)
- ◆ State the proposed program's goal(s), objective(s) and the indicator(s) proposed for measuring achievements for each objective. As appropriate, include objectives and indicators for capacity building as well as technical areas of intervention. PVC recognizes that the proposed design may contain both over-arching project objectives as well as secondary or intermediate objectives that correspond to specific interventions. We encourage the applicant to develop a concise, manageable set of objectives that accurately reflects the results and impact that the program seeks to achieve. Relate this discussion to the program description in Section E.5.
 - ◆ Describe your overall program design, including program strategies that address the key constraints described in the problem analysis. Provide a thorough justification of your choice of interventions and strategies. Avoid discussing the global importance of Child Survival interventions. Address the site. If your PVO has implemented primary health programs in this country, discuss this experience and describe how the proposed program builds on your in-country experience.
 - ◆ Discuss the relationship this program will have with other existing or future health-related activities in the program area (including those of this and other PVOs, NGOs, private and traditional providers, and government), and discuss the role the program will have in relation to the health facilities in the proposed program area.
 - ◆ Describe any operations research (OR) or other studies that will assess or test the effectiveness of new approaches.
 - ◆ Describe any new methods, strategies, or materials to be developed or used by the proposed program, which may be applicable on a wider scale or beneficial in other areas or programs. Describe, also, any planned operations research to test or assess the effectiveness of new approaches.

Note: The applicant may use a matrix to graphically convey program Objectives, Indicator(s) for each objective, activities that will support each objective, and how the indicators will be measured, including a) a set of results-oriented program objectives which identifies what the program hopes to accomplish; b) indicator(s) that match each program objective and define what will be measured to determine whether the objective has been achieved; c) how the indicator will be measured; and d) the inputs or major activities that will be needed to achieve the objective. There is no one format for a graphic. Several different, equally acceptable, styles have been presented by different organizations. A brief composite is presented here.

Program Goal:

OBJECTIVES	INDICATOR	MEASUREMENT METHOD, DATA SOURCE AND FREQUENCY OF DATA COLLECTION	MAJOR PLANNED ACTIVITIES
What are the program objectives ? - Institutional - Intervention specific The objective should: - be specific - clearly state the type of change expected - be clear about who or what is changing individual, groups or organizations	What indicators will signal the achievement of the objective? Indicators should be: - direct, - objective & precise - quantitative, where possible - practical - sufficiently reliable for confident decision-making	What specific source of data for each indicator? What methods will be used to obtain it? If data doesn't already exist, make provision for funding it in the budget.	What activities will support achievement of the objective?

c. Child Survival Interventions (No page limitation apart from overall limitations for document)

For each intervention:(refer to C.2 for the list of interventions supported under the CS GP)

- ◆ State the objectives and indicators that the organization will use to measure achievements of the specific interventions over the life of the program. Identify the target groups for the proposed intervention.

- ◆ Describe and provide a rationale for the proposed strategy, and methods that will be used to implement the intervention. Briefly describe how the program will address the essential elements of the intervention (such as quality, access, behavior change and education of community members, essential household actions, etc.). Briefly describe the specific activities to be implemented, who will implement these activities, and how the program will integrate the activities with, or will effectively support, existing health related services in the area.
- ◆ Provide an explanation of, and justification for, any proposed intervention activities or strategies that differ from MOH policy.

d. Management Plan (2-3 pages)

- ◆ Describe the proposed management structure for program supervision and financial management, including the roles of the headquarters vis a vis the field, and supervisory structures in the field.
- ◆ Identify and briefly describe the qualifications (training and experience) for the key field staff positions to be funded through the proposed program. List the main responsibilities and estimate the number of person-months programmed for each position. Describe proposed staff competence in each child survival intervention, and plans for upgrading their skills.
- ◆ For each kind of field staff with whom the proposed program will work (including MOH and NGO health workers, their supervisors, and all other personnel to be involved in program's child survival services): Describe the type and number of health workers (e.g., nurse, community health worker, traditional birth attendant), identify their current organizational affiliation and work location (or note that these staff are to be recruited in the future). Indicate whether they are paid or volunteers, their main duties related to the supervision and provision of child survival services, and estimated time devoted to the proposed child survival activities.
- ◆ Describe any committees or community groups with which the proposed program will work, their role in the child survival program, and the number of each type of group. Briefly explain the rationale for working with these types and numbers of health facilities, workers, and committees. Briefly describe how these entities will relate to and support each other. Discuss how the program will work with these groups, including the frequency and nature of

interaction, and identify which staff will work with the groups.

- ◆ Describe your tentative plans for training each type of health worker to deliver child survival services. Describe how you will decide the topics, content, methods, and duration of training. Describe also how you are going to monitor and evaluate the quality and effectiveness of the trainings.
- ◆ If volunteers will be involved in the delivery of child survival services, explain how the program or other organizations will sustain the volunteers' participation.

e. Work Plan (2-3 pages -- as part of the body of the application)

- ◆ Propose a brief, but illustrative work plan for the life of the program. If you plan to phase in interventions or sites, include a schedule. Include a more detailed action plan (calendar of key activities) for the first year of the program, including activity, approximate timing, and assigned responsibility. DO NOT SUBMIT A DIP.

f. Performance Monitoring and Evaluation (1-2 pages)

- ◆ Discuss how you will measure program achievements and impact. Relate this discussion to Section E.5.b.
- ◆ Discuss your plans for conducting assessments, studies, or surveys in the program site if this proposed program is funded. Include your plans for learning more about the coverage, quality, and needs of existing health services, and about the beliefs, practices, and vocabulary of the local population, and client satisfaction. Describe how this information will be used to revise the program's objectives and plans.
- ◆ Describe the strategies, methods, and tools that will be used to monitor and improve the performance of health workers and the quality, effectiveness and coverage of intervention activities (including those carried out in cooperation with other organizations).

E.6. Partnerships and Capacity Building (1-2 pages)

- ◆ Describe planned partnerships with non-governmental and local governmental organizations, including the reason for the relationship, involvement of partners in design of the proposed program, activities to be carried out, the local partners contribution to the partnership and how the partnership will be evaluated.

Identify any other organizations that are already working in the site with the program's proposed partners. Letters of collaboration and endorsement from cooperating governmental and other organizations, dated within three months of the application, should be included in the annex.

- ◆ Describe the current capacity, including financial, human, and material resources, of local partners, and how the program plans to increase the managerial and technical skills of staff in those local institutions that are to sustain program activities. Identify capacity building objectives, indicators and how a change in capacity will be documented. What evidence is there that these local organizations will sustain program activities?
- ◆ Describe how you will measure changes in the organizational or technical capacity of your partners.

E.7. Sustainability (2-3 pages)

- ◆ Define what "sustainability" will mean for your proposed program from the perspective of your PVO. Describe what the program hopes to leave in place at the end of this child survival grant , i.e., your sustainability objectives, and how you will document if you have achieved these objectives.
- ◆ Describe the financial or other support from communities, the MOH, NGOs, other local organizations, or other donors, that will be required to sustain program-related activities or benefits after the end of USAID/BHR/PVC funding. Describe the plans for involving these organizations and groups in planning for sustainability.⁷
- ◆ Describe what local technical resources will be developed to replace or expand existing ones.
- ◆ Describe the community's involvement in the proposed program and how its resources and priorities will contribute to the program's long-term sustainability.
- ◆ Discuss the cost-effectiveness of the program, and the extent to which the proposed partnerships(s) achieve cost savings or economies of scale. Define the beneficiary population for the proposed program, estimate the number of beneficiaries the program will serve, and calculate the cost per beneficiary.
- ◆ Briefly describe how the program will address financial sustainability, including, if applicable: (a) financial

7 All PVOs who receive funding will be required to submit a sustainability plan with their DIP.

commitments by other organizations; (b) a strategy for obtaining private sector support; or (c) cost-recovery methods to be explored. Discuss the process for documenting that an adequate flow of resources are in place at the end of the grant

- ◆ Describe how you will measure change in organizational, operational, technical, behavioral and/or financial sustainability of your local partners and clients.
- ◆ Applicants applying for funding for a 3rd cycle need to describe the PVO's devolution strategy including a detailed plan for transitioning to other funding or transferring all activities to the local partner. Describe how the benefits of the program might be scaled up to a broader population, either by the PVO or other actors.

E.8. Past Performance

- ◆ Discuss the PVOs adherence to the terms and conditions of its current or past contracts, cooperative agreement or grants, including the technical, financial, and administrative aspects of performance.
- ◆ If your PVO has been funded in the past in this country through the CSGP, include the summary and recommendations sections of all previous CSGP evaluations and the entire most recent evaluation in an annex of this application. Provide a thorough discussion here of how your program has addressed each recommendation of the most recent evaluation (if conducted within the last three years).
- ◆ If you have been funded in this country by other institutions, include the summary and recommendations of any existing evaluations of that program.
- ◆ List separately, in an annex:
 - All federal- and non-federal-funded contracts, grants or cooperative agreements involving similar or related programs in the country proposed, for the last three years. Include: (1) name of the organization or agency funding the programs, (2) contact person at the organization, (3) total program budget, areas where activities were or are being implemented, (4) start and end dates, and (5) main program activities.
 - All other applications pending for federal- or non-federal funding for similar or related programs in the proposed country;

E.9. BHR/PVC Strategic Plan

◆ Contribution to PVC Strategic Objective and Intermediate Results

Describe how the proposed program will contribute to the attainment of PVCs strategic plan. Specifically, discuss how the proposed program will: (1) increase the operational or technical capacity of your organization, particularly as it relates to increased capacity to achieve and monitor program performance and to enhance program sustainability; (2) strengthen the partnership between your organization and USAID; (3) build local level partnerships, and improve the capacity and resources of NGOs; (4) improve the mobilization of resources or increase the financial diversity of your organization; and (5) how will your organization use program results to increase public awareness of your organizations development activities.

- ◆ PVC's annual Results Report consolidates the achievements of all active PVC cooperative agreements under the five categories cited above can be found in Annex G of this document. This report will provide your organization with a clear picture of how the current programs contribute to the attainment of PVC's objectives. The report outlines the indicators used by PVC to measure achievements of the Office's strategic objective and intermediate results and provides data on the results achieved by our PVO partners this year. Copies of PVC's Strategic Plan can be obtained from the BHR/PVC Office or found on PVC Homepage

[http://www.info.usaid.gov/hum_response/pvc/pvcpubs.html].

APPLICATION FOR FEDERAL ASSISTANCE

1. TYPE OF SUBMISSION:		2. DATE SUBMITTED	Applicant Identifier NA
Application	Preapplication NA	3. DATE RECEIVED BY STATE NA	State Application Identifier NA
Construction X Non- Construction	Construction Non- Construction		
		4. DATE RECVD BY FEDERAL AGENCY	Federal Identifier NA
5. APPLICATION INFORMATION			
Legal Name:		Organizational Unit	
Address (give only county, state, and zip code):		Name and telephone number of person to be contacted on matters involving this application (give area code)	
6. EMPLOYER IDENTIFICATION NUMBER (EIN):		7. TYPE OF APPLICATION: (enter appropriate letter in box)	
		M	
8. TYPE OF APPLICATION X New ContinuationRevision If Revision, enter appropriate letter(s) in box(es) A. Increase Award D. Decrease Duration B. Decrease Award E. Other (specify): C. Increase Duration		<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> A. State B. County C. Municipal D. Township E. Interstate F. Intermunicipal G. Special Dist. </div> <div style="width: 50%;"> H. Independent School Dist I. State Controlled Institurion of Higher Learning J. Indian Tribe K. Individual L. Profit Organizaition M. Other (specify) </div> </div>	
10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: NA		9. NAME OF FEDERAL AGENCY USAID/BHR/PVC	

TITLE:		11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT:	
12. AREAS AFFECTED (Cities, Counties, States, etc.):			
13. PROPOSED PROJECT		14. CONGRESSIONAL DISTRICTS OF:	
START DATE	END DATE	a. Applicant	b. Project
		NA	NA
15. ESTIMATED FUNDING:		16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?	
a. Federal	\$	a. YES. THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS REVIEW ON: DATE B. NO. <input checked="" type="checkbox"/> PROGRAM IS NOT COVERED BY E.O. 12372 <input checked="" type="checkbox"/> OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW	
b. Applicant	\$		
c. State	\$ NA		
d. Local	\$ NA		
e. Other	\$		
f. Program Income	\$		
g. TOTAL	\$		
17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?		Yes If "Yes", attach an explanation No	
18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT, THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.			
a. Type Name of Authorized Representative		b. Title	c. Telephone Number
d. Signature of Authorized Representative			e. Date Signed

Public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget. Paperwork Reduction Project (0348-0043), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET, SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

This is a standard form used by applicants as a required facesheet for preapplications and applications submitted for Federal assistance. It will be used by Federal agencies to obtain applicant certification that States which have established a review and comment procedure in response to Executive Order 12372 and have selected the program to be included in their process, have been given an opportunity to review the applicant's submission.

Item:	Entry:	address of the applicant, and the name and telephone number of the person to contact on matters related to this application.
1.	Self-explanatory.	
2.	Date application submitted to Federal agency (or State if applicable) & applicant's control number (if applicable).	
3.	State use only (if applicable).	
4.	If this application is to continue or revise an existing award, enter present Federal identifier number. If for a new project, leave blank.	
5.	Legal name of applicant, name of primary organizational unit which will undertake the assistance activity, complete	
		6. Enter Employer Identification Number (EIN) as assigned by the Internal Revenue Service.
		7. Enter the appropriate letter in the space provided.
		8. Check appropriate box and enter appropriate letter(s) in the space(s) provided:
		- "New" means a new assistance award.
		- "Continuation" means an extension for an additional funding/budget period for a

project with a projected completion date.

- "Revision" means any change in the Federal Government's financial obligation or contingent liability from an existing obligation.

9. Name of Federal agency from which assistance is being requested with this application.
10. Use the Catalog of Federal Domestic Assistance number and title of the program under which assistance is requested.
11. Enter a brief descriptive title of the project. If more than one program is involved, you should append an explanation on a separate sheet. If appropriate (e.g.,

Item: Entry:

construction or real property projects), attach a map showing project location. For preapplications, use a separate sheet to provide a summary description of this project.

12. List only the largest political entities affected (e.g., State, counties, cities).
13. Self-explanatory.
14. List the applicant's Congressional District and any

District(s) affected by the program or project.

15. Amount requested or to be contributed during the first funding/budget period by each contributor. Value of in-kind contributions should be included on appropriate lines as applicable. If the action will result in a dollar change to an existing award, indicate only the amount of the change. For decreases, enclose the amounts in parentheses. If both basic and supplemental amounts are included, show breakdown on an attached sheet. For multiple program funding, use totals and show breakdown using same categories as item 15.

16. Applications should contact the State Single Point of Contact (SPOC) for Federal Executive Order 12372 to determine whether the application is subject to the State intergovernment review process.

17. This question applies to the applicant organization, not the person who signs as the authorized representative. Categories of debt include delinquent audit disallowances loans and taxes.

18. To be signed by the authorized representative of the applicant. A copy of the governing body's authorization for you to sign this application as official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

SF 424 Back (Rev. 4-92)

ANNEX A

RFA 938-99-A-0500-15

PVO CHILD SURVIVAL GRANTS PROGRAM

Standard Form 424A

Budget Information - Non-Construction Programs

SECTION A - BUDGET SUMMARY					
Grant Program Function or Activity {a}	Catalog of Fderal Domestic Assistance Number {b}	Estimated Unobligated Funds		New or F	
		Federal {c}	Non-Federal {d}	Federal {e}	Nor
1. Headquarters	\$ NA	\$ NA	\$ NA	\$	\$
2. Field	NA	NA	NA		
3. NA	NA	NA	NA	NA	
4. NA	NA	NA	NA	NA	
5. TOTALS	\$ NA	\$ NA	\$ NA	\$	\$
SECTION B - BUDGET CATEGORIES					
6. Object Class Categories	Grant Program, Function or Activity				
	Federal	Non-Federal	{3}		
a. Personnel (1)	\$	\$	\$ NA	\$	\$
b. Fringe Benefits (1)			NA		
c. Travel (1)			NA		
d. Equipment (3)			NA		
e. Supplies (3)			NA		
f. Contractual (3)			NA		

g. Construction N/A			NA	NA	
h. Other (1), (2) (see notes)			NA	NA	
i. Total Direct Charges (sum of 6a-6h)			NA	NA	
j. Indirect Charges (4)			NA	NA	
k. TOTALS (sum of 6i and 6j)	\$	\$	\$	\$	\$
7. Program Income	\$	\$	\$	\$	\$

STANDARD FORM 424A (cont'd)

SECTION C - NON-FEDERAL RESOURCES						
(a) Grant Program		(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS	
8.	Headquarters	\$	\$ NA	\$	\$	
9.	Field		NA			
10.	NA	NA	NA	NA		
11.	NA	NA	NA	NA		
12.	TOTAL (sum of lines 8-11)	\$	\$ NA	\$	\$	
SECTION D - FORECASTED CASH NEEDS						
13. Federal		Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th quarter
		\$	\$	\$	\$	\$
14. Non-Federal						
15. TOTAL (sum of lines 13 and 14)						
SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT						
(a) Grant Program		Future Funding Periods				
		(b) First	(c) Second	(d) Third	(e) Fourth	
16.	Headquarters	\$	\$	\$	\$	
17.	Field					
18.	NA	NA	NA	NA	NA	
19.	NA	NA	NA	NA	NA	
20.	TOTAL (sum of lines 16-19)	\$	\$	\$	\$	
SECTION F - OTHER BUDGET INFORMATION						

21. Direct Charges:	22. Indirect Charges:
23. Remarks:	

Standard Form 424A (cont'd.)
INSTRUCTIONS FOR THE SF 424A

Public reporting burden for this collection of information is estimated to average 180 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0044), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET, SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

General Instructions

This form is designed so that application can be made for funds from one or more grant programs. In preparing the budget, adhere to any existing Federal grantor agency guidelines which prescribe how and whether budgeted amounts should be separately show for different functions or activities within the program. For some programs, grantor agencies may require budgets to be separately shown by function or activity. For other programs, grantor agencies may require a breakdown by function or activity. Sections A, B, C and D should include budget estimates for the whole project except when applying for assistance which requires Federal authorization in annual or other funding period increments. In the latter case, Section A, B, C and D should provide the budget for the first budget period (usually a year) and Section E should present the need for Federal assistance in the

subsequent budget periods. All applications should contain a breakdown by the object class categories shown in Lines a-k of Section B.

Section A. Budget Summary
Lines 1-4 Columns (a) and (b)

For applications pertaining to a single Federal grant program (Federal Domestic Assistance Catalog number) and not requiring a functional or activity breakdown, enter on Line 1 under Column (a) the catalog program title and the catalog number in Column (b).

For applications pertaining to a single program requiring budget amounts by multiple functions or activities, enter the name of each activity or function on each line in Column (a), and enter the catalog number in Column (b). For applications pertaining to multiple programs where none of the programs require a breakdown by function or activity, enter the catalog program title on each line in Column (a) and the respective

catalog number on each line in Column (b).

For applications pertaining to multiple programs where one or more programs require a breakdown by function or activity, prepare a separate sheet for each program requiring the breakdown. Additional sheets should be used when one form does not provide adequate space for all breakdown of data required. However, when more than one sheet is used, the first page should provide the summary totals by programs.

Lines 1-4, Columns (c) through (g)

For new applications, leave Columns (c) and (d) blank. For each line entry in Columns (a) and (b), enter in Columns (e), (f), and (g) the appropriate amounts of funds needed to support the project for the first funding period (usually a year).

For continuing grant program applications, submit these forms before the end of each funding period as required by the grantor agency. Enter in Column (c) and (d) the estimated amounts of funds which will remain unobligated at the end of the grant funding period only if the Federal grantor agency instructions provide for this. Otherwise, leave these columns blank. Enter in columns (e) and (f) the amounts of funds needed for the upcoming period. The amount(s) in Column (g) should be the sum of amounts in Columns (e) and (f).

For supplemental grants and changes to existing grants, do

not use Columns (c) and (d). Enter in Column (e) the amount of the increase or decrease of Federal funds and enter in Column (f) the amount of the increase of non-Federal funds. In Column (g) enter the new total budgeted amount (Federal and non-Federal) which includes the total previous authorized budgeted amounts plus or minus, as appropriate, the amounts shown in Columns (e) and (f). The amount(s) in Column (g) should not equal the sum of amounts in Columns (e) and (f).

Line 5 - Show the totals for all columns used.

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Standard Form 424A (cont'd.)

INSTRUCTIONS FOR THE SF 424A (continued)

Section B. Budget Categories

In the column headings (1) enter Federal and (2) enter Non-Federal. When additional sheets are prepared for Section A, provide similar column headings on each sheet. For each program, function or activity, fill in the total requirements for funds (both Federal and non-Federal) by object class categories.

Lines 6a-i - Show the totals of Lines 6a to 6h in each column.

Line 6j - Show the amount of indirect cost.

Line 6k - Enter the total of amounts on Lines 6i and 6j. For all applications for new grants and continuation grants the total amount in column (5), Line 6k, should be the same as the total amount shown in Section A, Column (g), Line 5. For supplemental grants and changes to grants, the total amount of the increase or decrease as shown in Columns (1)-(4), Line 6k should be the same as the sum of the amounts in Section A, Columns (e) and (f) on Line 5.

Line 7 - Enter the estimated amount of income, if any, expected to be generated from this project. Do not add or subtract this amount from the total project amount. Show under the program narrative statement the nature and source of income. The estimated amount of program income may be considered by the federal grantor agency in

determining the total amount of the grant.

Section C. Non-Federal Resources

Lines 8-11 - Enter amounts of non-Federal resources that will be used on the grant. If in-kind contributions are included, provide a brief explanation on a separate sheet.

Column (a) - Enter the program titles identical to Column (a), Section A. A breakdown by function or activity is not necessary.

Column (b) - Enter the contribution to be made by the applicant.

Column (c) - Enter the amount of the State's cash and in-kind contribution if the applicant is not a State or State agency. Applicants which are a State or State agencies should leave this column blank.

Column (d) - Enter the amount of cash and in-kind contributions to be made from all other sources.

Column (e) - Enter totals of Columns (b), (c), and (d).

Line 12 - Enter the total for each of Columns (b)-(e). The amount in Column (e) should be equal to the amount on Line 5, Column (f) Section A.

Section D. Forecasted Cash Needs

Line 13 - Enter the amount of cash needed by quarter from the grantor agency during the first year.

Line 14 - Enter the amount of cash from all other sources needed by quarter during the first year.

Line 15 - Enter the totals of amounts on Lines 13 and 14.

Section E. Budget Estimates of Federal Funds Needed for Balance of the Project

Lines 16-19 - Enter in Column (a) the same grant program titles shown in Column (a), Section A. A breakdown by function or activity is not necessary. For new applications and continuation grant applications, enter in the proper columns amounts of Federal funds which will be needed to complete the program or project over the succeeding funding periods (usually in years). This section need not be completed for revisions (amendments, changes, or supplements) to funds for the current year of existing grants.

If more than four lines are needed to list the program titles, submit additional schedules as necessary.

Line 20 - Enter the total for each of the Columns (b)-(e). When additional schedules are prepared for this Section, annotate accordingly and show the overall totals on this line.

Section F. Other Budget Information

Line 21 - Use this space to explain amounts for individual direct object-class cost

categories that may appear to be out of the ordinary or to explain the details as required by Federal grantor agency.

Line 22 - Enter the type of indirect rate (provisional, predetermined, final or fixed) that will be in effect during the funding period, the estimated amount of the base to which the rate is applied, and the total indirect expense.

Line 23 - Provide any other explanations or comments deemed necessary.

The following object class categories are those required on USAID Form 424A (Section B - Budget Categories):

a. Personnel

The category includes the salary of each long-term and short-term, paid position for the total estimated life-of-project, except consultants, and the projected cost-of-living or bonus/merit increase for each position.

b. Fringe Benefits

This category includes the amount and percentage of fringe benefits for each headquarters and field personnel identified above. Include here all allowances such as housing, schooling, leave benefits, and other items.

c. Travel

This category includes all projected travel, per diem and other related costs for personnel except consultants. Include the method by which airfare costs were determined; i.e. quotes for coach and if per diems are based on established policies.

d. Equipment

In accordance with 22 CFR 226, 'equipment' means tangible non-expendable personal property, including exempt property charged directly to the award having a useful life of more than one year and an acquisition cost of \$5,000 or more per unit. Information should be included in the application on how pricing was determined for each piece of the equipment.

There are statutory constraints relating to the purchase of agricultural commodities, motor vehicles, pharmaceuticals, pesticides, rubber compounding chemicals and plasticizers, used equipment and fertilizer with USAID project funds. PVOs can obtain specific information on these regulations on USAID Web Site at <http://www.info.usaid.gov/pubs/ads>.

e. Supplies

In accordance with 22 CFR 226, 'supplies' means all personal property excluding equipment, intangible property, debt instruments and interventions.

There are statutory constraints relating to the purchase of agricultural commodities, motor vehicles, pharmaceuticals, pesticides, rubber compounding chemicals and plasticizers, used equipment and fertilizer with USAID project funds. PVOs can obtain specific information on these regulations on USAID Web Site at <http://www.info.usaid.gov/pubs/ads/300/312/htm>.

f. Contractual Services

This category is for all subcontracts with organizations which will provide services to the project and any short- or long-term consultant cost including fees, travel and per diem. This category is not to be used for sub-grants, which should be included in Other.

g Construction

N/A

h. Other

PVOs are to identify all costs associated with training of project personnel.

PVOs planning to use USAID funds to send project staff or local counterparts for training in the U.S. or a country other than the host country, will be required to follow the guidance on USAID Participant Training Regulations, which may be found on the the USAID Web Site at <http://www.info.usaid.gov/pubs/ads>.

The PVO should provide information on any costs attributed to the project not associated above; i.e. communications, facilities, fuel vehicles, repair, maintenance and insurance.

Include in this budget class category all subgrants.

j. Indirect Charges

Include a copy of the PVO's most recent agreement negotiated indirect cost rate agreement (NICRA) from cognizant audit agency showing the overhead and/or general administrative rate.

USAID Form 424A, Section C should reflect the PVO's and other sources' cash contribution to this program. A cash match means that funds are used to support the budget elements discussed above. This does not include volunteer labor from U.S. or host country sources. The cash value of donated equipment or supplies, must be documentable.

A narrative that justifies the costs as appropriate and necessary for the successful completion of the program should be attached to USAID Form 424.

ANNEX B
RFA 938-99-A-0500-15

PVO CHILD SURVIVAL GRANTS PROGRAM
USAID MISSION ADDRESSES
(In Alphabetical Order by Country)

Country	Contact Person	Official Address	Commercial Courier
Angola	Mr. James Anderson Mission Director	USAID/Luanda Dept. of State Wash. DC. 20521-2550	USAID/Angola 64 Rua da Liga Africana Luanda, Angola Tel.: 244-2-399-540
Bangladesh	Mr. Charles Habis Tech./PVO Liaison Officer	USAID/Dhaka Dept. of State Wash. D.C. 20521-6120	USAID/Bangladesh American Embassy Madhani Ave., Baridhara Dhaka, Bangladesh Tel.: 880-2-884-700-22
Bolivia	Ms. Ileana Baca Technical/PVO Liaison Officer	American Embassy USAID/La Paz Unit #3914 APO AA 34032	USAID/Bolivia 109 Calles No. 9 Obrajes La Paz, Bolivia Tel.: 591-2-786-544/786-147
Cambodia	Mr. Jeffrey Ashley/ Mr. Randy Kolstad PHN Office	American Embassy USAID/Phnom Phen Box P APO AP 96546	USAID/Cambodia No. 18 Mongkul Eam Stareet #228 Phnom Phen, Cambodia Tel.: 855-23-427-640
Congo ¹	Mr. John Grayzel Mission Director	USAID/Kinshasa Unit #31550 APO AE 09828	Tel.: 243-12-21533
Ecuador	Mr. Jack Galloway PHN Officer	USAID/Quito American Embassy Unit # 5330 APO AA 34039-3420	USAID/Ecuador 1573 Ave. Colombia Y Queseras del Medio Edificio Computec Quito, Ecuador Tel.: 593-2-562-890

1. Democratic Republic of Congo (DROC): Final decisions would require clarification and stabilization of the present situation and agreement by USAID mission.

Egypt	Ms. Mellen Tanamly Sup. Health/Dev. Officer	USAID/Cairo Unit # 64902 APO AE 09839- 4902	USAID/Cairo 106 Kasr El Aini St. Cairo Center Bldg., 9th Flr Carden City Cairo, Egypt Tel.: 20-2-355- 7371
El Salvador	Mr. Charles North PHN Officer	USAID/San Salvador Unit # 3110 APO AA 34023	USAID//El Salvador Urbanizacion Y Boulevard Santa Elena Antiquo Cuscatlan, La Libertad, San Salvador, El Salvador, C.A. Tel.: 503-2-981- 666
Ethiopia	Wuletta and Hanna Nekatebeb PHN Office	USAID/Addis Ababa Dept. of State Wash. D.C. 20521-2030	USAID/Ethiopia Riverside Building Off Asmara Rd & Bole (Olympia) Addis Ababa, Ethiopia Tel: 251-1-510- 088
Eritrea	Ms. Ann Hirschey Office of Health	USAID/Asmara Dept. of State Wash. D.C. 29521-7170	USAID/Asmara Hiwet St. House No. 19 P.O. Box 957 291-0 Asmara, Eritrea

Country	Contact Person	Official Address	Commercial Courier
Georgia (Republic of Georgia)	Mr. Akram Eltom Regional Health Advisor	USAID/Tbilisi Dept. of State Wash. D.C. 20523-3180	USAID/Tbilisi 4/6 Orbeliani St. Tbilisi 380026, Republic of Georgia Tel.: 995-32-98-23-93
Guatemala , C.A.	Mr. Baudilio Lopez Office of Health	USAID/Guatemala a American Embassy Unit #3323 APO AA 34024	USAID/Guatemala 1 Calle 7-66, Zone 9 01009 Guatemala Guatemala, C.A. Tel.: 502-2-31-15-41
Ghana	Mr. Joseph Amuzu Technical Officer	USAID/Accra Dept. of State Wash. D.C. 20521-2020	USAID/Ghana E 45/3 Independence Ave. Accra, Ghana Tel: 233-21-225-087/228-467
Guinea	Ms. Mariama Bah General Dev. Office	USAID/Conakry Dept. of State Wash. D.C. 20521-2110	USAID/Guinea Camayenne Corniche Nord Quartier Cameroun Conakry, Guinea Tel.: 224-41-2163/41-2502
Haiti	Ms. Nancy Nolan PHN Office	USAID/Port-au-Prince Dept. of State Wash. D.C. 20521-3400	USAID/Haiti #17 Harry Truman Blvd. Port-au-Prince, Haiti Tel.: 509-22-5500/22-3085
Honduras	Mr. Herbert Caudill Ms. Roberta Cavitt DF Office	USAID/Tegucigalpa Unit # 2927 APO AA 34022	USAID/Honduras Avenida La Paz Frente Embajada Americana Tegucigalpa D.C., Honduras Tel.: 504-36-9320

India	Ms. Heather Goldman Office of Social Develop.	USAID/New Delhi Dept. of State Wash. D.C. 20521-9000	USAID/American Embassy Shantipath, Chanakyapuri New Delhi 110021, India Tel.: 91-11-611-3033
Indonesia	Ms. Lana Dakan, Ms. Sri Durjadi Boedihardjo	American Embassy/USAID Box #4 APO AP 96520	USAID/American Embassy Jl. Medan Merdeka Selatan 3-5 Jakarta 10110, Indonesia 62-21-344-2211
Kenya	Mr. Victor Masbayi Office of Pop. & Health	USAID/Nairobi Unit # 64102 APO AE 09831-4102	USAID Towers - RFMC The Crescent, Parklands Nairobi, Kenya Tel.: 254-2-751-613
Madagascar	Mr. Benjamin Adriamitantsoa Tech. Officer	USAID/Antananarivo Dept. Of State Wash. D.C. 20521-2040	USAID/Madagascar Immeuble Vonisoa III Avenue Docteur Ravohangy Anosy, Antananarivo 101 Madagascar Tel.: 261-2-254-89
Malawi	Ms. Joan LaRosa Health/Develop. Officer	USAID/Lilongwe Dept. of State Wash. D.C. 20521-2280	USAID/malawi NICO House, 1st Floor Lilongwe 3, Malawi Tel.: 265-782-455
Mali	Ms. Karen Hawkins Health/Dev. Officer	USAID/Bamako Dept. Of State Washin. D.C. 20521-2050	USAID/Mali Immeuble Dotemougou Rue Raymond Poincarre & Rue 319 Quartier du Fleuve Bamako, Mali Tel.: 223-223-602/224-542

Country	Contact Person	Official Address	Commercial Courier
Morocco	Ms. Michelle Moloney-Kitts PHN Office	American Embassy USAID/Rabat PSC 74 Box 022 APO AE 09718-5000	USAID/Morocco 137 Avenue Allal ben Abdallah Rabat, Morocco Tel.: 212-776-2265
Mozambique	Mr. Kurt Rockman PPD Office	USAID/Maputo Dept. of State Wash. D.C. 20521-2330	USAID/Mozambique Rua Faria de Sousa 107 Maputo, Mozambique Tel.: 258-1-490-726
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2. West and Central Africa (WCA) Region (Burkina Faso, Cameroon, Togo and Ivory Coast): PVOs proposing for WCA must consult with those individual on the contact list for guidance on priority interventions. The programs proposed must have regional relevance, no reliance on a US mission, partnership with local organizations and other US and international PVOs to the extent possible, and diversified funding sources for the proposed activity.

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United States Agency for International Development
Bureau for Humanitarian Response

PVO Child Survival Grants Program
Technical Reference Materials

Office of Private and Voluntary Cooperation

DRAFT
August 28, 1998

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This document briefly describes the essential elements of the child survival interventions supported through the PVO Child Survival Grants Program, and complements the "Guide for Detailed Implementation Plans." BHR/PVC is grateful for the many

contributions to this document from public health specialists consulted through the Johns Hopkins University PVO Child Survival Support Program, the American College of Nurse Midwives, the BASICS, SEATS, LINKAGES, and OMNI projects, and through other offices of USAID, and welcomes further suggestions for improvement. Please submit your suggestions to Katherine Jones (internet e-mail: kjones@usaid.gov).

GENERAL REFERENCE MATERIALS

This document includes information on reference materials important for the design and implementation of high quality PVO child survival programs. References that specifically apply to an intervention are listed after each intervention description. The following references are relevant to PVO child survival programs generally.

Highly Recommended Reference Materials

1. Murray J, Manoncourt S. Use of an Integrated Health Facility Assessment for Planning Maternal and Child Health Programs: Results from Four African Countries. Published for USAID by the BASICS Project, 1998. Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: 312-6900.

2. Survey Trainer's Guide for PVO Child Survival Program Rapid Knowledge, Practice, and Coverage (KPC) Surveys. September 1997, The Johns Hopkins University PVO Child Survival Support Program. The Guide is designed for use by those who participate in the Training of Survey Trainers (TOST) workshop. The standardized KPC survey may be used by CS programs to collect quantitative baseline information, set measurable objectives, and measure achievement of objectives.

3. Murray, John, Gabriella Newes Adeyi, Judith Graeff, Rebecca Fields, Mark Rasmuson, Rene Salgado, Tina Sanghvi. 1997. Emphasis Behaviors in Maternal and Child Health: Focussing on Caretaker Behaviors to Develop Maternal and Child Health Programs in Communities. Published for USAID by the BASICS Project. This document discusses sixteen emphasis behaviors (developed by a multi-disciplinary team of medical and behavioral specialists) that, if practiced by caretakers, could improve maternal and child health in developing countries. Also includes a discussion of the criteria used for identifying the sixteen behaviors, and the technical justification for each of the emphasis behaviors. Methods to help project managers select which of the sixteen behaviors to focus on in their projects, develop strategies to target the emphasis behaviors, and monitor and evaluate behavior change, are also reviewed. (14 pages plus annexes) (This document was provided to the participants of the May 1997 BASICS PVO/IMCI workshop held in Silver Spring, Maryland.)

4. Child Health Dialogue (CHD) is a quarterly international newsletter, focusing on child health and prevention, aimed at health and development workers at district level. This newsletter contains clear, practical advice on preventing and treating the main childhood illnesses. CHD is free to readers in developing countries. In addition to the international English edition, 11 regional language editions are

GENERAL REFERENCE MATERIALS

also produced. An adapted text is available on electronic mail in selected countries via Healthnet. To subscribe to a published version of Child Health Dialogue, contact; Mary Helena, Publications Secretary, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB. Tel: +44 171 2420606, Fax: +44 171 2420041, Email: ahrtag@gn.apc.org, Internet: <http://www.poptel.org.uk/ahrtag/> For the electronic version of CHD please contact: hnet@usa.healthnet.org. AHRTAG produces a range of free publications for health workers in developing countries.

Other Recommended Reference Materials

5. de Negri B, LD Brown, O Hernandez, J Rosenbaum, and D Roter. Improving Interpersonal Communication Between Health Care Providers and Clients. Available from the Quality Assurance Project, 7200 Wisconsin Ave., Suite 600, Bethesda, MD 20814. Phone: 301-654-8338, fax: 301-941-8427.

6. A Toolbox for Building Health Communication Capacity. HealthCom, Communication for Child Survival Project, 1995. Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: 312-6900.

7. Primary Health Care Management Advancement Programme (PHCMAPS), 1993, Samboon Vacharotai Foundation, Bangkok, Thailand, FAX 662-448-6462.

8. Powers MB. Sustainability Findings of 12 Expanded PVO Child Survival Projects. PVO Child Survival Support Program, June 1995 (available from USAID/BHR/PVC/CSH or from JHU/PVO CSSP).

9. Saving Lives Today and Tomorrow: A Decade Report on USAID's Child Survival Program. A 36 page document written and produced for USAID by the Center for International Health Information (CIHI), 1601 North Kent Street, Suite 1014, Arlington, VA 22209, phone: (703) 524-5225.

10. The Progress of Nations, The State of the World's Children (both published by UNICEF annually).

Internet References

USAID strategies can be retrieved from the INTERNET. The INTERNET address of the Agency Gopher is: gopher.info.usaid.gov.

- (a) "Stabilizing World Population Growth and Protecting Human Health: USAID's Strategy" can be found under "Stabilizing Population Growth/Protecting Health" in the USAID Gopher Root Menu.
- (b) Specific strategic objectives of each USAID Mission can be found under "Regional/Country Focus" in the USAID Gopher

GENERAL REFERENCE MATERIALS

Root Menu. Within the "Regional/Country Focus," each country with a USAID Mission is listed. The "FY 1996 Congressional Presentation" within the country listing contains strategic objectives of each USAID Mission.

Homepage of the World Health Organization: Use the search engine to find several interesting entries on child survival topics.
<http://www.who.ch/>

Child Immunization is widely regarded as one of the most cost effective public health interventions for reducing child morbidity and mortality. The true goal of immunization programs is to reduce the incidence of vaccine-preventable diseases in children by means of high coverage with potent EPI vaccines by the end of the first year of life. The EPI target diseases are poliomyelitis, diphtheria, pertussis, tetanus and measles. The WHO goal is to achieve national coverage rates of 90% for all vaccines by 2000, although the difficulty in achieving this goal within a particular community varies according to local resources and conditions.

Tetanus toxoid should be provided to all pregnant women in the form of two doses during pregnancy, up to a total of five doses for lifetime protection. Where feasible, all women of child bearing age should be vaccinated with tetanus toxoid, depending on resources and MOH policy.

WHO also recommends immunization against tuberculosis with BCG vaccine in countries or regions where TB is common. Although there is uncertainty surrounding the effectiveness of BCG in later childhood, there appears to be agreement that BCG vaccination protects infants and young children against tuberculous meningitis and disseminated TB. Immunization against yellow fever is recommended in endemic countries.

WHO promotes integration of Hepatitis B vaccination into the vaccination programs of all countries. This has been difficult in some developing countries as the vaccine remains relatively expensive compared with OPV, DPT, and measles vaccine. Despite the cost, it should form part of the routine schedule in countries with a hepatitis B carrier prevalence of 2% or higher. In countries where mother-child transmission is a major cause of infection, such as in South-East Asia, the first vaccination should be given at birth. In countries where mother-child transmission is not so important the vaccine can be commenced at the same time as DPT.

Children who fail to receive vaccination, or who fail to complete the series, are rarely randomly distributed within a project area. They are usually clustered within 'pockets of need,' defined by geography, poverty, ethnicity, and/or other demographic factors. Identification of these groups and the barriers they face is an important first step in addressing the barriers and boosting vaccination coverage.

Another important consideration is how to address 'missed opportunities.' This term refers to contact between a health care provider and a child eligible for vaccination, but the vaccination is not given. Approaches to reducing missed opportunities include: combining the vaccination and health care clinics; making vaccination available whenever the clinic is

open; training health care workers to review the vaccination status of all children presenting to the clinic and providing vaccination where indicated; and/or providing vaccine and training to community health workers who visit children at home.

Ensuring provision of potent vaccine is an important component of an immunization program. The provision of ineffective vaccine is worse than providing no vaccine at all as it damages the community's confidence in the vaccination program ("My child got the vaccine but still got measles"), subjects the child to the inconvenience and risks of vaccination without benefit, and marks the child as having been vaccinated, therefore precluding effective vaccination in the future. Contaminated or poorly maintained vaccine is also more likely to cause reactions and illness than pure and well maintained vaccine. PVO staff should take all possible steps to ensure that the vaccines provided are in good condition. This is done by obtaining vaccine from a source which adheres to WHO quality requirements, and by tracking and maintaining the cold chain from this source to the child who will receive the vaccine, and, if possible, monitoring efficacy at the population level through surveillance of immunizable diseases.

Vitamin A Supplementation (optional)

Vitamin A supplementation can substantially reduce under-five mortality in areas where there is vitamin A deficiency. Child immunization contacts may be a good opportunity to provide vitamin A supplements to infants and children over six months of age (and to younger infants who are not breastfed, depending on national policy). PVOs may consider including vitamin A supplementation as part of immunization programs, if feasible, even if the program is not otherwise involved in nutrition interventions. (Please refer to the Nutrition and Micronutrients section of this document.)

Polio Eradication Activities (optional)

PVOs are encouraged to support polio eradication activities in their program areas, including surveillance for Acute Flaccid Paralysis (AFP), support of National Immunization Days (NIDs), education and social mobilization, and/or support for routine immunization, where feasible.

Surveillance (optional)

Surveillance of immunizable diseases can provide a real measure of program impact and early warning of epidemics. Where possible, surveillance should be done for polio (AFP), measles, and neonatal tetanus. Surveillance can be passive and done at the clinic level. Each case of vaccine-preventable disease is

investigated to determine whether or not the child received vaccination. The percentage of cases vaccinated can be used to monitor the efficacy of the vaccine, when used in combination with the estimated percentage of the population vaccinated.¹ Evidence that the vaccine efficacy is declining and the number of cases increasing should prompt investigation of the cold chain, administration procedures, or a search for new clusters of unvaccinated people in the population.

Where a disease surveillance system already exists in the project area, PVOs should participate and contribute to this system, and use the resulting data. In areas without disease surveillance, PVOs should consider working towards establishing such a system.

Surveillance for polio eradication may involve weekly reporting of cases of Acute Flaccid Paralysis (AFP) through key informants at the community level and cooperation with health facilities in collecting and transporting laboratory specimens.

Highly Recommended Reference Materials 1. EPI Essentials: A Guide for Program Officers. John Snow, Inc. Second Edition, August 1989. Available from: Information Center, BASICS Project, 1600 Wilson Blvd., Suite 300, Arlington, VA 22209. Phone: (703) 312-6800, Fax: (703) 312-6900.

2. Training for Mid-Level Managers (MLM). Published by WHO, 1991. (WHO/EPI/MLM/91.2)

Other Recommended Reference Materials

3. Immunization in Practice: A Guide for Health Workers Who Give Vaccines. WHO. Published by Oxford University Press, New York.

Internet References

WHO web site at <http://www.who.org> contains detailed descriptions of WHO recommendations and the rationale behind them, as well as extensive technical information on vaccines. This information can be found using the web site's in-house search engine. Information about EPI policy can be found at <http://www.who.org/programmes/gpv/gEnglish/avail/gpvcatalog/policy.htm#Im3>. Further details on the current recommended EPI

¹ ЦжГсSsfГс Гs Яб rЯГf оГГfсЕГf Я SsЯсoЯжo ГжЯсr fсж srFS еГжсESГё ЪrГс еГжoГсЯГГf Еf oЯSГS зЯoоFсЯsГo Ясo еГжoГсЯГГf Еf ссeГжЯsFсe зЯoоFсЯsГo ЯжГ ебсsГoе зЯoоFсЯsFсe ГfFоЯoI oЯс SFсeбI яГ жГЯo ЕfГ srГ ГжЯсrё ссж srГ SsЯсoЯжo ГжЯсre Ясo fГжsrГж оГsЯFбSe SГГ ЦжГсSsfГс ЪПе пГжсFГж чте рссoГжс шye Гs Ябё сFГбo CзЯбзЯsFсe Еf зЯoоFсГ ГfFоЯoIё пГбб ЪтЦ ЗЛКЙМЙИЛЗЖЙЙёкё

schedule, see

http://www.who.org/programmes/gpv/gEnglish/epi/epi_over.htm

Malnutrition contributes to over half of under-five mortality in developing countries, and even mild malnutrition increases the risk of death. The goal of this intervention is to decrease malnutrition-associated under-five mortality by improving the nutritional status of infants, children, and/or pregnant and lactating women. Approaches to prevent child malnutrition, rehabilitate malnourished children, and promote maternal nutrition, including micronutrient activities, as well as approaches designed to increase household availability of foods, are discussed below. PVOs implementing a nutrition and micronutrients intervention may include any of these approaches in their programs, but are not expected to implement them all.

Leading authorities in public health nutrition have recently reviewed epidemiologic and programmatic data to identify the most important nutrition behaviors and the effectiveness of programs to change these behaviors. Six primary behaviors were selected on the basis of criteria such as the demonstrated relationship to morbidity and mortality, ability to be changed through cost-effective public health programs, and measurability, and published in 1997 for USAID by the BASICS Project in "Improving Child Health Through Nutrition: The Nutrition Minimum Package." This "Minpack" of nutrition interventions aims to achieve the following six nutrition behaviors:

- Exclusive breastfeeding of infants until about 6 months of age;
- Appropriate complementary feeding from about 6 months of age, and continued breastfeeding until 24 months;
- Appropriate nutritional management of all sick children (continued feeding and increased fluids during illness, increased feeding after illness, and provision of 2 doses of vitamin A to measles cases);
- Consumption of vitamin A-rich foods and/or vitamin A supplements by women, infants, and children;
- Consumption of iron/folate tablets by all pregnant women; and
- Consumption of iodized salt regularly by all families.

Programs in countries or areas where vitamin A deficiency is a public health problem are particularly encouraged to consider including a vitamin A intervention. Several research studies in Asia and Sub-Saharan Africa have demonstrated that vitamin A supplementation can reduce mortality in children between six and fifty-nine months of age by 23 to 34 percent. Providing vitamin A supplements to this age group every three to six months may be feasible through many PVO child survival

programs, even if other nutrition and micronutrient activities are not being implemented.

Most of the approaches discussed in this section require specialized local assessments to develop concrete and culturally appropriate strategies and messages, appropriate training with extensive practice, and strong supervision and quality control, to ensure health workers have good technical and counselling skills.

Nutritional Improvement for Infants and Children

Interventions to prevent childhood malnutrition should promote feeding practices which ensure adequate growth and reduce the detrimental effects of illness. Programs should emphasize optimal feeding practices which differ by the age of the infant/child, and by whether the child is ill or well.

Previously, WHO recommended introducing complementary feeding at age 4-6 months because it was believed that breast milk alone was not adequate to support growth of some infants during this period. Furthermore, it was also thought that complementary feeding should begin before 6 months in order to get infants used to eating other foods. However, recommendations have recently been changed following a study in Honduras comparing food consumption patterns and growth of infants who started eating foods at four months to those who began eating complementary foods at 6 months, which confirmed that early initiation does not result in improved growth velocity.

One new approach to nutrition rehabilitation is the Hearth nutrition model, which involves mothers, families, and neighborhoods in rehabilitating their own malnourished children, using local food and know-how. The goal of this approach is to not only rehabilitate the participating children, but also reduce the prevalence of childhood malnutrition in the community and to energize the mothers and community to take broader and sustaining action against malnutrition and poor health. The Hearth intervention takes place in the context of growth monitoring and counselling and micronutrient supplementation. In the early 1990s, the Hearth approach was initiated in Bangladesh by World Relief Corporation and the Christian Service Society as part of a PVO child survival program, in Haiti by the Hospital Albert Schweitzer, and in Vietnam by Save the Children (US) and local government. An evaluation of the Haiti program indicates that while the short-term rehabilitation of severely and moderately malnourished children was highly motivating to mothers, in the long term the most important impact of the program appears to have been the prevention of nutritional deterioration in mildly malnourished children. The evaluation of the Vietnam program found that severe and moderate malnutrition in the community was

virtually eliminated, and led to plans for national implementation.

Guidelines for a health facility-based approach to the management of childhood malnutrition are included in the WHO/UNICEF materials for the Integrated Management of Childhood Illness. The IMCI charts and manuals for health facility clinicians include guidelines for assessing and treating malnourished children, counselling on complementary feeding, vitamin A and iron supplementation, and treatment of helminths.

Growth Monitoring, Counseling, and Follow-up

Growth monitoring can be used to identify children who are falling behind in growth, provide the opportunity to take corrective action, and reinforce positive feeding behaviors. Effective growth monitoring programs include the following elements: measuring the population at risk frequently; educating caregivers regarding the child's growth pattern; identifying faltering children promptly; determining the cause of growth faltering; counseling caregivers of growth faltering children; and providing for appropriate follow-up care. Appropriate training with extensive practice, and strong supervision and quality control, to ensure health workers have good technical and counselling skills, is particularly important for growth monitoring activities.

As some children will fail to gain weight despite improved feeding practices, programs can consider providing extra food for growth faltering children, ensuring access to effective medical care, and making plans for follow-up of children returning to the community. Growth monitoring efforts can also include methods to identify the children least likely to attend growth monitoring sessions and target them for weighing.

Maternal Nutrition

Maternal nutrition status relates to maternal and child health and survival in several ways.

Birth weight is the single most important determinant of an infant's chance of survival. Low birth weight is the result of intra-uterine growth retardation and/or prematurity. Low caloric intake or insufficient weight gain by the mother during pregnancy and low pre-pregnancy weight significantly contribute to low birth weight. Improving the nutritional status of pregnant women improves birth weight, thus decreasing infant deaths, and protects the health of the mother. It also helps in the proper physical and cognitive development of the unborn baby.

The major causes of maternal mortality are hemorrhage, eclampsia, unsafe abortion, infection, and obstructed labor. Malnutrition plays a role in most of these. Obstructed labor

often occurs among nutritionally stunted women, who are short in stature as a result of chronic malnutrition and poor diet quality. Malnutrition and anemia intensify the severity of infection and contribute to deaths from hemorrhage and infection.

Both well-nourished and mildly malnourished women produce breastmilk of high quality and adequate quantity. Only under extreme conditions is the supply and energy and protein content of breastmilk affected. However, mothers with adequate fat stores produce milk higher in fat content. Consequently, their infants need to suckle less to obtain sufficient energy. The micronutrient content, however, of the breastmilk may be compromised depending on a woman's diet.

A mother's own health and nutritional status can also be compromised if her nutritional stores are depleted to nourish her child. Short intervals between pregnancies and/or the overlap of lactation and pregnancy into the third trimester (an overlap which is experienced by as many as half the women in some countries) can result in lower weight gains in pregnancy. This sets up a cycle of inter-generational growth failure.

If a woman is sick, anemic, malnourished, depressed, or exhausted from heavy physical labor, her care-giving ability will be diminished. Poor nutrition can limit a mother's ability to seek preventive and curative care for herself and for her children.

Recommended practices to protect the nutritional status of women between the ages of 10 and 49 years include:

- increased caloric intake, and/or reduced workloads, to meet increased nutritional demands during adolescent growth, pregnancy, and lactation, and to improve pre-pregnancy nutritional status;
- increased micronutrient intake through: daily consumption of fruits and vegetables, and/or through use of micronutrient supplements, and/or through consumption of fortified foods, whichever is feasible and appropriate (Women of all ages should be encouraged to eat a wide variety of micronutrient rich foods, especially those rich in vitamin A, iron, and folic acid. In iodine deficient areas where iodine-fortified foods are not available, iodine supplements are also recommended); and
- delaying the first pregnancy, increasing birth intervals, and reducing fertility.

Quality health care services can improve maternal nutritional status through effective nutrition and breastfeeding counselling, maternal care, and family planning services.

Counselling men to make more food available to households, and/or to women within the household, may also contribute to improved maternal nutrition status and improved birth outcomes.

Interventions designed to improve the nutritional status of non-pregnant adolescent girls may have a positive impact on both mothers and children, but are beyond the scope of this program. PVOs may propose interventions in adolescent reproductive health, but fund these activities from sources other than BHR/PVC (such as PVO match funds).

Pregnancy

During pregnancy, a woman should increase her energy intake by 300 kcal. per day, and gain a total of 9-18 kg. This can be achieved by adding an additional full serving per day of the staple food (rice, cornmeal, millet, sorghum, yams, bread, etc.). Adding additional calories through a variety of available local foods, including protein sources, is the ideal, but not always possible. Where food security is a problem, recommending an increase in the family staple is the easiest and cheapest way to increase the caloric intake of a pregnant woman.

Studies show that 30-70% of women in developing countries are anemic. In many of these countries, it is impossible to correct iron deficiency anemia in pregnant women with dietary measures alone. Thus, iron/folate supplements are recommended for all pregnant women.

Lactation

A lactating woman needs to increase her energy consumption by about 500 kcal/day to meet the demands of lactation, particularly if she cannot draw from fat stores accumulated during pregnancy. Increased energy intake may also help to build a mother's confidence in her ability to breastfeed exclusively. As in pregnancy, an additional one or two servings of the staple food can provide these calories.

A lactating woman and her baby will both benefit if she receives a Vitamin A supplement immediately postpartum, or as soon as possible within the first eight weeks after delivery. PVOs can coordinate efforts for postpartum vitamin A capsule administration with local maternal care delivery activities.

Micronutrient Interventions

The micronutrients most suitable for community-based PVO programs include vitamin A, iron/folic acid, and iodine. Each of the major micronutrients affecting child and maternal health require special implementation strategies in programming, and are thus described separately here.

Although micronutrient fortification of staple foods is a long-accepted and successful means of protecting nutritional status in countries with suitable food distribution systems, this strategy is unlikely to be feasible for most PVO programs. Where micronutrient fortified foods are both available and affordable in the project area, PVOs should encourage their consumption and monitor consumption where feasible.

Vitamin A

Subclinical vitamin A deficiency can be present and cause increased mortality in children between the ages of 6 and 59 months, even where the prevalence of xerophthalmia is low. Periodic supplements of high dose vitamin A for children aged 6 to 59 months in vitamin A deficient regions can prevent blindness and substantially reduce mortality.

Immediate treatment with high dose vitamin A capsules is particularly important for children with xerophthalmia, severe infectious disease (particularly measles), and severe protein-energy malnutrition. PVO programs can develop methods to identify these children, offer prompt referral, and ensure they receive appropriate doses of vitamin A supplements.

Supplementation with high dose vitamin A immediately postpartum, or within eight weeks after delivery, increases vitamin A in breastmilk and maternal serum. Frequent supplementation with small doses vitamin A (not exceeding 10,000 IU daily or 25,000 IU weekly) is also appropriate, and may be beneficial, for all women of childbearing age. However, large

doses of vitamin A may cause birth defects, particularly early in pregnancy. Thus, a woman of childbearing age should receive high dose vitamin A only when it is reasonably certain that she is not pregnant (immediately postpartum, or within eight weeks after delivery), or when she herself requires treatment for potentially blinding xerophthalmia (in cases of acute corneal lesions).

A long-term preventive strategy may include education about locally appropriate sources of vitamin A. Vitamin A precursors in orange/yellow fruits and vegetables are twice as effective in enhancing serum vitamin A levels as those found in dark green leafy vegetables, but neither fruits nor vegetables are as effective as animal products (dairy products, eggs) in maintaining stores. The absorption of vitamin A precursors is improved when fruits and vegetables are mixed with a source of fat. Thus, nutrition education messages should be adapted to promote consumption of locally available sources of vitamin A and fats, wherever possible. In areas where sources of vitamin A are scarce or expensive, PVOs may consider promoting home gardening or other agricultural activities as complementary activities in the Child Survival Program, emphasizing foods high in vitamin A content.

Iodine

Iodine deficiency increases the risk of spontaneous abortions and still births, and causes impaired fetal brain development and infant death. It is the cause of goiter and cretinism, which reduces the mental capacity of infants. Promoting and monitoring consumption of iodine-fortified products such as salt, if available, may be practical for some child survival programs, and could have a measurable impact on mortality and morbidity. In program areas where iodine deficiency is a problem, and where iodized salt is not available, programs may consider providing either oral or injectable iodine supplements. Other alternatives include water iodization or administration of Lugol's iodine solution monthly.

Iron

Iron deficiency anemia affects both women and children. It diminishes the ability to fight infection, increases risk of death in children with malaria, and is the most common micronutrient deficiency among women in developing countries, where approximately 40 percent of women of reproductive age are anemic. During pregnancy, the rate of anemia rises to 50 percent in many countries, and is much higher in some Asian countries. In pregnant women, anemia increases the risk of complications and death due to spontaneous abortion and the stress of labor, and increases the chance of low birth weight and subsequent infant

death. Anemia causes fatigue and apathy in both women and children.

Iron deficiency is by far the most common cause of anemia. Where anemia is due to dietary iron deficiency and significant dietary sources of iron are available, anemia prevention can take the form of nutrition education. Inclusion of nutritional messages discouraging iron-inhibiting foods/fluids (such as tea with meals) and promoting iron-enhancing substances (such as vitamin C-rich foods) may contribute to the effectiveness of a dietary approach. Current research, however, suggests that requirements for iron during pregnancy can not be met when animal products are rarely consumed. Thus iron/folate supplementation is recommended for all pregnant women.

Even in areas with significant malaria morbidity and intestinal parasitism, the causes of anemia are multifactorial and include iron deficiency. Therefore, although treatment of chronic malaria prevents and treats the associated severe anemia, some sources also recommend iron supplements for treatment of the concurrent iron deficiency.

Anemia in children may be treated with iron supplements. However, implementation guidelines for programs are still under development. A forthcoming INACG publication recommends giving "oral iron supplements daily (12.5 mg per day) to infants 6 months to 1 year of age. If the prevalence of anemia is known to be very high (40 percent or more) continue supplementation until 24 months of age. For low birthweight infants, start supplementation at 3 months."

Failures of iron supplementation programs have largely been the result of unreliable supply, and lack of counselling about dosage and on overcoming or coping with the minor side effects. Thus, PVOs involved in iron/folate supplementation are recommended to devote particular attention to these issues.

In areas where the prevalence of hookworm is greater than 20 percent among children aged two to five years, periodic (usually twice a year) deworming is indicated for children over 2 years, and for pregnant women. The contribution of hookworm as a cause of anemia generally increases with age and severity of infestation. Thus older children, and pregnant women are more at risk. In spite of earlier published information on contraindications of anti-helminthics in pregnancy, they are safe if not given during the first trimester. While women and children will usually become reinfected, the improvement of anemia in both women and children, and increased growth in children is significant. Deworming of children less than two years of age is not recommended as these children have much less exposure to infection.

Supplemental Feeding

Supplemental feeding activities can be important in times of severe food shortages. However, by itself, supplemental feeding is not a sustainable approach to correcting maternal or child malnutrition. Where PVOs are engaged in such programs, the integration of other health and nutrition activities known to improve nutritional status can enhance the effectiveness of the feeding program.

Well designed feeding programs have explicit nutrition objectives and a plan for sustaining health and nutrition activities when the supplemental feeding ends. When a child enters a supplemental feeding program, an assessment of infant feeding practices is performed to determine possible problems which contribute to the child's condition. When problems are identified, a caretaker receives the same quality nutrition counselling services and follow-up as described in the Growth Monitoring section of this document.

Home Gardens and Other Agricultural Activities

As a complement to the child survival program, household food security can be addressed by PVOs through a strategy to increase the household supply of and access to nutrient rich foods. Since research shows that animal sources of iron and vitamin A are significantly more bio-available than vegetable and fruit sources, increasing animal sources is also encouraged.

Most families in developing countries engage in agricultural activities for economic reasons. Therefore home gardens and other agricultural activities do not, by themselves, constitute a nutrition intervention. The role gardens play in improving the diet of mothers and children largely depends upon the objectives of the activity and the implementation strategy. Agricultural programs established solely for the purpose of income generation or worker incentives have not demonstrated positive impact on household nutritional status. Targeted gardening programs, with specific nutritional objectives, have succeeded in demonstrating nutrition-related improvements.

Mothers of small children in developing countries have extremely heavy workloads, and additional agricultural activities to be undertaken primarily by women can further increase the burden. The DIP for agricultural activities, therefore, should describe which family members will be involved in the activity, family time and resource constraints to participation, PVO activities to promote consumption of the products by target populations at the household level, and the means of monitoring consumption.

Appropriate storage is important for the success of agricultural activities. Measures to reduce food losses should be promoted. For example, solar drying can increase the year-round availability of some foods.

Child survival programs may enhance the effectiveness of their efforts by becoming familiar with the activities of PVOs/NGOs specializing in small-scale agricultural programs.

Funding for agricultural activities in child survival programs should come from PVO matching resources rather than from AID/BHR/PVC funds.

Recommended General Nutrition Reference Materials

Sanghvi, T. and Murray, J. Improving Child Health Through Nutrition: The Nutrition Minimum Package. BASICS, 1997.

Piwoz E., Ideal Nutrition Practices. Appendix E in the Report on the Fifth Annual Latin America Regional PVO Child Survival Workshop, Cerro Verde, El Salvador, 1995. Available from PVO CSSP.

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Pinstrup-Andersen, P., Pelletier, D. Alderman, Eds. Child Growth and Nutrition in Developing Countries, Priorities for Action. Cornell University Press, 1995.

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Facts for Feeding: Guidelines for Appropriate Complementary Feeding of Breastfed Children 6-24 Months and Beyond. LINKAGES. 1997.

Brown, K.H., Dewey, K.G., Allen, L.H. Complementary Feeding of Children in Developing Countries: A Review of Current Scientific Knowledge, WHO/UNICEF, (forthcoming in 1997)

World Vision International, Procurement and Use of Milk Products: Policy Governing the Use of Milk Products, World Vision International, Child Survival Unit, 220 I St. N.E. Suite 270, Washington, D.C. 20002.

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Nabarro DN. Preconditions for Successful Growth Monitoring Programs in South Asia. PVO Child Survival Technical Report, Vol. 3, No. 2, PVO Child Survival Support Program, November 1992.

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Growth Monitoring and Promotion: Behavioral Issues in Child Survival Programs. Prepared for the Office of Health, USAID, by Ann Brownlee. Reference number PNABG 752. Available from Development Experience Clearinghouse (DEC),

How to Weigh and Measure Children: Assessing the Nutritional Status of Young Children in Household Surveys. National Household Survey Capability Program. United Nations Department of Technical Co-operation for Development and Statistical Office, New York, 1986.

Maternal Nutrition

Galloway, R. and Cohn A. eds, Indicators for Reproductive Health Program Evaluation: Final Report of the Subcommittee on Women' Nutrition, The Evaluation Project, 1995. Available from the Carolina Population Center.

Baker, J., Martin, L., Piwoz, E. The Time to Act: Women's Nutrition and its Consequences for Child Survival and Reproductive Health in Africa, 1996. (Available in English and French from the SARA Project. (Although specifically geared toward African women, the nutritional problems and recommendations are applicable worldwide, especially in Asia.)

Vitamin A

Sommer A. Vitamin A Deficiency and its Consequences: A Field Guide to Detection and Control. Third Edition. World Health Organization, Geneva, 1995.

Vitamin A Supplements: A guide to their use in the treatment and prevention of vitamin A deficiency and xerophthalmia, Second edition. WHO/UNICEF/IVACG Task Force, World Health Organization, Geneva, 1997.

Prevalence of Vitamin A Deficiency: Micronutrient Deficiency Information System Working Paper #2 WHO/NUT/95.3, WHO, 1995.

How to Use the HKI Food Frequency Method to Assess Community Risk of Vitamin A Deficiency, 1993. Available from Helen Keller International.

The Vitamin A references listed above are available through the OMNI Project.

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Storms D, Quinley J, Editors. A Field Guide for Adding Vitamin A Interventions to PVO Child Survival Projects: Recommendations for Child Survival Project Managers: Report of a Special PVO Child Survival Task Force on Vitamin A, Baltimore, Maryland, 1988. Available from PVO CSSP.

Iodine

Dunn JT, van der Haar F. A Practical Guide to the Correction of Iodine Deficiency. International Council for the Control of Iodine Deficiency Disorders, WHO/UNICEF, 1990.

Monitoring Universal Salt Iodization Programs, PAMM, MI, 1995. Available from OMNI.

Iron

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Iron Deficiency in Infancy and Childhood: A Report of the International Nutritional Anemia Consultative Group (INACG), September 1979.

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PVO Child Survival Community Micronutrient Interventions, Iron Manual. Helen Keller International (in draft)

Helminth Control

Promoting Child Health Through Helminth Control Programmes: Report of a Workshop, 24th & 25th February 1997 held at Programme Division, UNICEF Headquarters, New York. Available from: Programme Division, Health Section (TA-24A), UNICEF, 3 United Nations Plaza, New York, NY 10017, Tel: (212) 824-6330, Fax: 824-6464/6462/6460.

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Marsh, R., Talukder, A, Baker, S., Bloem, M. Improving Food Security through Home Gardening: A Case Study from Bangladesh.

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Internet References

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www.jsi.com/intl/omni/home (contains links to several other nutrition websites).

Pan American Health Organization (PAHO). NutriInfo was established by the Food and Nutrition Program to improve access to basic and applied nutrition information in the Americas. This site has links to many other nutrition related sites.
<http://www.paho.org/english/hpnnutri.htm>

Contact Information for References

Basic Support for Institutionalizing Child Survival (BASICS): 1600 Wilson Blvd. Suite 300, Arlington, VA 22209
Tel:(703)312-6800 FAX: (703)312-6900.

Carolina Population Center, University of North Carolina at Chapel Hill, CB#8120, 304 University Square East, Chapel Hill, NC 27516-3997.

Cooperative for Asst. & Relief Everywhere (CARE): 151 Ellis St. Atlanta, Ga. 30303. Tel: (404)681-2552 FAX: (404)577-1205/6662.

Development Experience Clearinghouse (DEC):1611 N. Kent St. Suite 200, Rosslyn Va. 22209 Tel.: (703) 351-4006. ext 106 FAX: 703-351-4039.

Helen Keller International: 90 Washington Street, 15th Floor, New York, NY 10006. Tel: (212) 943-0890. FAX: (212) 943-1220. HKI has many additional references not listed here.

INACG, 1126 16th St. NW, Wash. D.C. 20036, TEL: (202) 659-0074. FAX: 202-659-3617, e-mail: OMNI@dc.ilsa.org.

LINKAGES: c/o The Academy for Educational Development
(AED), 1255 23rd St. NW, Suite 400, Washington, D.C.
20037.

The OMNI Project, John Snow, Inc., 1616 N. Ft. Myer Drive,
11th Floor, Arlington, VA 22209. Phone: (703) 528-7474,
FAX: (703) 528-7480, Internet: OMNI_Project@jsi.com.

PVO Child Survival Support Program (CSSP) The Johns Hopkins
University, 103 East Mount Royal Avenue, Room 2C,
Baltimore, MD 21202. Tel: (410) 659-4100 FAX: (410) 659-
4107.

SARA Project, c/o Academy for Educational Development
(AED), 1255 23rd St. N.W., Washington, D.C. 20037

Teaching Aids at Low Cost (TALC) Box 49, St. Albans, Herts.
AL15TX. United Kingdom. Tel: +441727853869, +441727846852.

Although the initiation of breastfeeding is almost universal in most developing countries, exclusive breastfeeding rates remain very low in many areas. Introduction of fluids, such as water or tea, are common in the first few days of life. Solid foods are often introduced at inappropriate ages, either putting the infant at early risk of infection from contamination, or limiting energy intake, if introduced too late. In some countries, the promotion of artificial infant feeding far exceeds the efforts to promote breastfeeding. Breastfeeding is an important crosscutting component of child survival and maternal health programs. Exclusive breastfeeding during the early months of life provides the ideal first food for infants, decreases malnutrition, decreases infection from foods and liquids introduced at an early age, confers immunity to disease, and decreases mortality. Suckling immediately after birth may also reduce the risk of death from postpartum bleeding.

Breastfeeding is also a major biological determinant of fertility. Exclusive breastfeeding, especially during the first six months postpartum, suppresses ovulation and menstruation, thereby protecting women's iron status, and allowing repletion of maternal iron stores. The Lactational Amenorrhea Method (LAM), the use of breastfeeding as a temporary family planning method, encourages the best breastfeeding practices, and provides natural protection against pregnancy.

PVOs are encouraged to link breastfeeding and LAM activities with other program interventions, such as maternal and newborn care, family planning, nutrition/micronutrients, and control of diarrheal diseases. Well designed breastfeeding programs promote the following important elements:

- Initiation of breastfeeding within about one hour of birth;
- Discouraging the practice of discarding colostrum;
- Frequent, on-demand feeding (including night feeds);
- Exclusive breastfeeding until the infant is about six months of age;
- LAM as a transition to other family planning methods;
- Introduction of appropriate weaning foods to supplement breastfeeding when the infant is around six months of age; and
- Sustained breastfeeding until 24 months of age, with gradual rather than abrupt weaning.

Breastfeeding promotion programs should be consistent with national policy, and developed according to cultural environment of the program area. Constraints to breastfeeding, such as maternal employment and heavy work loads, are considered when planning a breastfeeding intervention.

Measures to promote behavior change are the basis of breastfeeding promotion programs. However, approaches which are only educational rarely result in changes in behavior. Successful strategies developed in some countries, may be successfully adapted to other areas, such as the use of support groups which encourage mothers in their efforts to overcome obstacles to breastfeeding.

Many women believe they can not produce sufficient milk to satisfy the nutritional needs of their infants. However, the primary cause of insufficient breastmilk, for a normal or an underweight baby, is insufficient suckling. In a developing country situation it is a mistake for health care providers to tell a poor mother to "eat more" to make more breastmilk. The most important message is that she must suckle more frequently and for longer periods.

Previously, WHO recommended introducing complementary feeding at age 4-6 months because it was believed that breast milk alone was not adequate to support growth of some infants during this period. Furthermore, it was also thought that complementary feeding should begin before 6 months in order to get infants used to eating other foods. However, recommendations have recently been changed following a study in Honduras comparing food consumption patterns and growth of infants who started eating foods at four months to those who began eating complementary foods at 6 months, which confirmed that early initiation does not result in improved growth velocity.

Breastfeeding and HIV/AIDS

Some controversy exists regarding breastfeeding promotion in countries with high HIV/AIDS prevalence. In the majority of countries with BHR/PVC funded PVO child survival programs, under five mortality from causes other than AIDS far exceeds AIDS-associated mortality, and safe alternatives to breastfeeding are rarely available. In these cases, the recommendation remains to promote breastfeeding.

Lactational Amenorrheic Method (LAM)

LAM provides natural protection against pregnancy by changing the rate of release of natural hormones, thus preventing ovulation. When used correctly and consistently, LAM is very effective, yielding one pregnancy per 200 women in the first six months after childbirth. As commonly used, it is somewhat less effective, resulting in one pregnancy for every 50 women during the first six months after childbirth. A woman is naturally protected against pregnancy when:

BREASTFEEDING PROMOTION

- Her baby gets at least 85% of his or her feedings as breastmilk, and she breastfeeds her baby often, both day and night;
- Her menstrual periods have not returned; and
- Her baby is less than six months old.

If any of these three conditions are not being met, the woman should use another effective family planning method that does not interfere with breastfeeding, and keep breastfeeding her baby.

Counselling is an important part of LAM. Health providers should listen to women's concerns, answer their questions, and give clear and practical information about LAM, especially about how to breastfeed properly and when to start a follow-on contraceptive method.

Highly Recommended Reference Materials

The following references, are available from Wellstart International, 4062 First Avenue, San Diego, CA 92103-2045. Phone: 619-295-5192, FAX: 619-294-7787:

1. Community-based Breastfeeding Support: A Training Curriculum. Prepared by: USAID funded Expanded Promotion of Breastfeeding (EPB) Program. Wellstart International, 1996. (Three manuals including a planning manual, a guide for trainers and supervisors and a training curriculum. Available in English, Spanish and French)

2. Baker, J., Huffman, S., Labbok, M, Lung'aho M, and Sommerfelt, E. Tool Kit for Monitoring and Evaluating Breastfeeding (In Draft)

3. Favin, M., and Baume, C. A Guide to Qualitative Research for Improving Breastfeeding Practices, The Manoff Group and Wellstart International, 1996.

The following materials, as well as #1 above, are available from AED/LINKAGES, 1255 23rd St. NW, Washington, D.C. 20037 (202) 884-8700:

4. The Lactational Amenorrhea Method: Are You Offering Your Clients All the Options? (Also available in Spanish and French)

5. Breastfeeding: Protecting a Natural Resource

6. Breastfeeding and Family Planning: Mutual Goals, Vital Decisions

7. Guidelines for Breastfeeding in Family Planning and Child Survival Programs, Georgetown University, 1990.

BREASTFEEDING PROMOTION

Available from TALC, UK (Box 49, St. Albans, Herts, AL15TX, UK.
Phone: +441727853869, FAX: +441727846852:

8. Savage-King, F. and Burgess, Ann. Nutrition for Developing Countries, second ed. 1992. An entire chapter is devoted to breastfeeding.

Available from the Population Information Program, Center for Communication Programs, The Johns Hopkins School of Public Health, 111 Market Place, Baltimore, MD 21202. USA. FAX: (410) 659-6266:

9. Hatcher, R.A., Rinehart, W., Blackburn, R., and Geller, J.S. The Essentials of Contraceptive Technology. Baltimore, Johns Hopkins School of Public Health, Population Information Program, 1997. (Chapter 15 is devoted to LAM)

Internet References

La Leche League: <http://www.laleche.org/>

The World Alliance for Breastfeeding Action (WABA) is an international advocacy organization. Their website includes a link to a LAM information page, including FAQ's (Frequently Asked Questions.) <http://www.elogica.com.br/waba>

CONTROL OF DIARRHEAL DISEASE

Over two million children die each year in developing countries from three main types of diarrheal diseases: acute watery diarrhea, dysentery (bloody diarrhea), and persistent diarrhea (diarrhea lasting 14 days or more). Acute watery diarrhea is by far the most common type. However, episodes of dysentery and of persistent diarrhea are much more likely to be fatal.

Childhood Diarrhea in Developing Countries: Morbidity, Mortality, and Preventable Deaths²

Type of diarrhea	Percent of diarrhea cases	Percent of diarrhea deaths	Percent of deaths preventable by standard case management
Acute Watery	80%	50%	100%
Dysentery	10%	15%	80%
Persistent	10%	35%	80%
Total	100%	100%	90%

The goal of this intervention is to reduce diarrhea-associated mortality and malnutrition through:

- care in the home with fluids and dietary management for all diarrhea episodes,
- prompt and appropriate assessment, treatment, and counselling by health providers for severe episodes, and
- activities to prevent diarrhea, if these can be effectively implemented and evaluated.

Home Care and Case Management

At the household level, emphasis should be placed on:

- the early use of available food-based fluids (except heavily salted soups or very sweet drinks), and/or use of oral rehydration solution (ORS), if available and affordable;
- continued breastfeeding;
- small frequent feeds;

² WHO Fact Sheet No. 180: Reducing Mortality from Major Childhood Killer Diseases, September 1997. On the internet at: http://cdrwww.who.ch/pub/imci/fs_180.htm

- catch up feeding following diarrheal episodes; and
- recognition of, and prompt care seeking for, serious cases, including dysentery and persistent diarrhea.

Diarrhea case management by health workers should include:

- determining the duration of the diarrhea;
- determining whether blood is present;
- assessing the severity of dehydration; and
- providing appropriate treatment and counselling based on the type of diarrhea and severity of dehydration.

WHO has developed feeding recommendations for children who have persistent diarrhea, and advises treating dysentery for five days with an oral antibiotic recommended for Shigella. According to current protocols, metronidazole, along with other drugs for amoebiasis or giardiasis, are only very rarely indicated for use in children. Antidiarrheal agents, and the inappropriate use of antibiotics, should be discouraged. The use of home-made salt-sugar solution (SSS) is not recommended for most programs because the correct preparation of SSS at the household level has been found to be difficult, sometimes resulting in dangerously high concentrations of salt in the solution.

Quality improvement of case management services through training, monitoring, and/or supervising existing public, private, and/or traditional health providers, should be an important component of most diarrhea interventions. Good communication skills on the part of all involved health workers are essential for effective case management interventions. Appropriate clinic organization, good health worker morale, and adequate supplies are important in sustaining quality case management services.

Prevention of Diarrhea

Diarrhea interventions may include activities to prevent diarrheal diseases if these components can be effectively implemented and evaluated. CDD activities to prevent diarrhea may include promotion of:

- hand washing;
- use of plenty of water for hygiene and clean water for drinking;
- proper disposal of the stools of young children; and
- use of latrines.

Construction of water supply or waste disposal systems is beyond the scope of the PVO Child Survival Grants Program.

However, if they are linked to a diarrhea intervention, PVOs may consider allocating part of their matching funds to these activities.

Other more general preventive interventions, such as breastfeeding, improved weaning practices, and measles immunization, are all recommended child survival interventions in their own right, and thus should be considered separately (and, although part of an integrated child survival approach, should be described separately by the PVO, if planned).

Highly Recommended Reference Materials

1. Management of Childhood Illness, WHO Division of Child Health and Development, and UNICEF, 1995. The IMCI charts and manuals for health facility clinicians include revised guidelines for the dietary management of persistent diarrhea, and include only four signs to assess the severity of dehydration. Otherwise, the IMCI algorithm for assessment and treatment of dehydration and dysentery is similar to the algorithm in the CDD materials.

2. The Management and Prevention of Diarrhoea: Practical Guidelines. Third Edition. World Health Organization, Geneva, 1993.

Other Recommended Reference Materials

3. Supervisory Skills: Management of the Patient with Diarrhoea. World Health Organization, Programme for Control of Diarrhoeal Diseases, 1992.

4. Advising Mothers on Management of Diarrhoea in the Home: A Guide for Health Workers. World Health Organization, Programme for Control of Diarrhoeal Diseases, 1993 (CDD/93.1).

5. The Management of Bloody Diarrhoea in Young Children, World Health Organization, Programme for Control of Diarrhoeal Diseases, 1994.

6. Guide for Improving Diarrhoea Treatment Practices of Pharmacists and Licensed Drug Sellers. WHO.

7. Guidelines for Cholera Control. World Health Organization, Geneva, 1993.

Internet References/Ordering Documents from WHO

Several of the WHO CDD documents listed above are available on the website of the WHO Division of Child Health and Development (<http://www.who.ch/chd/pub/catalog.htm>). The website also contains an extensive reference list of WHO CDD documents, many of which are available from: The Director, Division of Child Health and Development, World Health Organization, CH-1211

CONTROL OF DIARRHEAL DISEASE

Geneva 27, Switzerland (fax: +41 (22) 791-4853 or 791-0746, e-mail: WESSELL@who.ch or JosephP@who.ch). Some of these WHO documents may have been adapted for use in your country by the MOH.

The Environmental Health Project is an excellent source of information on water and sanitation, and diarrheal disease reference materials. The e-mail bulletin board with current journal abstracts is particularly good. EHP may be contacted at:
1611 N. Kent St., Suite 300, Arlington, VA 22209
FAX: (703) 247-8610. Phone: (703) 247-8730
e-mail: ehp@access.digex.com.
Website: <http://www.access.digex.net/~ehp/webliog.html>

ARI: Acute Respiratory Infections (ARI) include common colds, ear infections, sore throats, bronchitis, pneumonia, and several other conditions. The incidence of ARI in children is about the same in developing countries as it is in developed countries, and acute respiratory infections are one of the most common reasons for pediatric consultations at health facilities everywhere in the world. Most acute respiratory infections are viral, mild, and self-limiting. Thus, most children with ARI do not need antibiotics. In fact, the use of antibiotics for common colds and coughs is not only inappropriate and costly, but may also accelerate the emergence of resistant bacteria. Thus, "ARI" is important from the perspective of rational drug use and appropriate case management of children seeking care from health workers.

Pneumonia: The incidence of childhood pneumonia is much higher in developing countries than it is in developed countries,³ and pneumonia is one of the leading causes of death in infants and children. The vast majority of all ARI-associated deaths in children under five years of age are due to pneumonia. Thus, efforts to reduce mortality should focus on pneumonia, rather than the full range of "ARI."

Prevention: Although there are a number of specific risk factors for pneumonia, the efficacy and feasibility of interventions to address these risk factors have not yet been demonstrated (see discussion at the end of this section). More general preventive child survival interventions, such as measles and pertussis immunization,⁴ breastfeeding promotion, and nutrition interventions, may reduce the incidence of pneumonia. However,

³ Incidence of pneumonia: The actual incidence of WHO algorithm positive pneumonia is very difficult to measure accurately, and is likely to vary between sites. The Global Burden of Disease and Injury Series (Murray CJL, Lopez AD. Volume II, Global Health Statistics, Harvard University Press, 1996, Table 105) estimates an average incidence of "lower respiratory infection" of 0.45 episodes per infant/child under five years of age per year in developing countries. In most sites with high under-five mortality, the incidence of algorithm positive pneumonia is probably most likely to be in the range of 0.3 to 0.6 episodes per under-five per year. Studies in several developing countries suggest that pneumonia incidence is higher in infants than in children.

(The incidence of algorithm positive pneumonia is likely to be somewhat higher in high altitude sites because childhood respiratory rates increase with altitude. The incidence of x-ray positive pneumonia is likely to be considerably lower in all areas than the incidence of algorithm positive pneumonia.)

⁴ Measles and pertussis: Measles and pertussis are two kinds of acute respiratory infections which substantially contribute to under-five mortality and which can be prevented through EPI vaccines. Pneumonia is associated with most measles and pertussis deaths.

these interventions, if implemented, should be promoted for their more general benefits in reducing illness and death due to all causes, rather than just as components of a pneumonia intervention.

Prompt and effective treatment: Most childhood pneumonia in developing countries is due to bacteria (mostly *Streptococcus pneumoniae* and *Haemophilus influenzae*). If treatment is started promptly, most cases of pneumonia can be effectively and cheaply treated with oral antibiotics. The problem is how to bring oral antibiotics within reach of all children who need them, and treating the right child, with the right drug, at the right time, while avoiding the use of antibiotics in children who do not need them. To address this problem, the World Health Organization has developed a Standard Case Management (SCM) protocol which enables peripheral health workers to detect childhood pneumonia based on a few clinical signs, without the use of a stethoscope, chest x-ray, or laboratory facilities. Several studies have demonstrated the feasibility of implementing SCM for pneumonia through peripheral health workers, and have shown that this approach can have a substantial impact on under-five mortality. Because the major impact of pneumonia intervention activities on mortality will be achieved through prompt and effective treatment of pneumonia episodes, rather than through prevention, the only ARI-specific intervention promoted by and included in the PVO Child Survival Grants Program is Pneumonia Case Management (PCM).

PVO CS Programs and Pneumonia Case Management: Although pneumonia is likely to be a leading cause of death in children under five years of age in all areas, the effectiveness of existing pneumonia case management services, and the feasibility and likely effectiveness of PVO-supported PCM activities, should be carefully assessed before a project decides to implement a pneumonia case management intervention. The goal of the PCM intervention is to reduce mortality in children under five years of age by providing Standard Case Management (SCM) early in the illness for a large proportion of all episodes of pneumonia. Therefore, PVOs should implement a Pneumonia Case Management intervention only if all three of the following essential components can be adequately addressed over the course of the program:

- Standard Case Management: Appropriate assessment, classification, treatment, referral, and counselling for childhood pneumonia by health workers;
- Adequate Access: Adequate access of ill children to SCM; and

PNEUMONIA CASE MANAGEMENT

- Prompt Care Seeking: Prompt recognition of pneumonia signs by caretakers, and prompt care seeking from appropriate health providers.

Standard Case Management

Standard Case Management protocol: WHO guidelines for case management of Acute Respiratory Infections, and for Integrated Management of Childhood Illness (IMCI), include a protocol for:

- Assessing a child with cough or difficult breathing,
- Classification based on a few clinical signs (including fast breathing and chest in-drawing),
- Provision of appropriate antibiotics or referral, depending on the classification, and
- Counselling of the caretaker.

Requirements for SCM: Standard Case Management means that all health workers who treat ill children, including physicians, follow current WHO or MOH protocols for ARI case management or for IMCI. To do this, health workers need:

- Effective training in Standard Case Management,
- Effective on-going support and supervision, and
- Adequate supplies of appropriate antibiotics.

Appropriate clinic organization and good health worker morale are also important in sustaining quality case management services.

SCM training: Good materials have been developed for assessing case management practices and health facility capacity, and for training health facility clinicians and community health workers in Standard Case Management (see references). Substantial hands-on practice in assessing and treating children and counselling caretakers, conducted with mothers, ill children, and small groups of trainees, should be an important part of all case management training courses. A video to demonstrate chest indrawing is also important because of the difficulty of finding cases of chest indrawing at most training sites.

Fast Breathing: All health workers who assess infants and children for pneumonia require an appropriate timing device to assess for fast breathing. Beeping timers may be available from UNICEF, WHO, or the MOH. Watches with second hands are also fine

because a health worker does NOT have to look at both the child and the watch at once to assess for fast breathing.⁵

Malaria and Pneumonia: The overlapping clinical presentation of malaria and pneumonia is an important consideration in all areas with falciparum malaria transmission. Studies conducted in several settings in Africa indicate that almost all children meeting a pneumonia case definition also have fever or a history of fever. In areas with falciparum malaria transmission, treatments for pneumonia alone in children who also have malaria, may result in death from malaria. Thus, in program areas with falciparum malaria transmission, treatment for malaria should be incorporated in the pneumonia case management protocols.⁶ (This issue is addressed in several WHO references cited below.)

Counselling about antibiotic use: Failure to feed a correct dose of antibiotics, or complete a course of treatment in children with pneumonia, will increase the risk of treatment failure and the development of antibiotic resistance.⁷ Thus, it is important

⁵ Watches and fast breathing: Instead of counting the number of breaths in one minute, the worker can determine whether it takes more or less than a minute to reach the cut-off point for fast breathing (60, 50, or 40, depending on the age of the child, and whether the health facility or CHW algorithm is being used). To do this, the worker looks at only the child while counting the number of breaths to the cut-off, and looks back at the watch only after reaching the cut-off, to see whether more or less than a minute has passed.

⁶ Pneumonia and malaria: Including malaria in pneumonia protocols is less important in areas where there is only non-falciparum malaria transmission, because, although non-falciparum malaria, and other infections causing high fever, and severe anemia, can also mimic mild pneumonia, mis-diagnosis is less likely to result in the death of the child. However, including case management for pneumonia in protocols for treating malaria is important in all areas where children are treated for malaria. Treatments for malaria alone in children who also have pneumonia may result in death from pneumonia, in any part of the world. Thus, case management for pneumonia should also be incorporated in the malaria protocols at the community, drug retailer, and health facility levels, in all areas (see section of this document on Control of Malaria).

⁷ Antimicrobial resistance: The development of antimicrobial resistance amongst organisms responsible for pneumonia represents a major threat to the pneumonia case management strategy. Prior to 1996, WHO recommended national ARI programs to develop a system of surveillance based on collection of nasopharyngeal and invasive isolates of *Streptococcus pneumoniae* and *Haemophilus influenzae* for laboratory in vitro sensitivity testing against commonly used antibiotics. However, this approach is no longer recommended because of the poor correlation of in-vitro findings with clinical outcomes, particularly for cotrimoxazole, but also for other antimicrobials. Data on clinical efficacy is now considered more useful for guiding national policy on choice of antibiotics for treating pneumonia (see CHD Interim Programme Report 1996). PVOs should
(continued...)

for health workers to provide effective counselling about the use of antibiotics to caretakers. Counselling about when to return to the health worker, continuing to breastfeed, feed fluids and food, and keeping the young infant warm, is also an important part of case management. Good communication skills on the part of all involved health workers are essential for effective case management interventions.

Improving case management: Many health workers who have not been trained in SCM, or who fail to receive adequate continuing supervision following their training, use inappropriate or out-of-date methods when managing children with acute respiratory infections. These inappropriate case management practices include: diagnosing pneumonia based on auscultation with a stethoscope or based on the presence of cough with fever, providing antibiotics to children who are unlikely to benefit from them, providing inappropriate drugs to children with ARI, and failing to provide effective counselling about the use of oral antibiotics. Thus, it is important for the program to work with as many of the health providers as possible who currently treat childhood pneumonia in the program site, by first learning about their current case management practices, and then working with providers to improve case management. In many sites, this may mean working with private practitioners and drug sellers. In areas where inpatient care for infants and children is feasible, child survival programs should work with health facilities to improve referral of infants and children with severe pneumonia and the quality of inpatient care.

If SCM is not feasible: If most childhood pneumonia cases in the area will continue to be treated by health providers who follow poor case management practices, or if supplies of appropriate antibiotics are likely to remain inadequate, then PCM may not be a good choice for an intervention to be supported through the child survival program.

Adequate Access

Importance of access: Several studies have documented a substantial decrease in the utilization of health services with increasing distance from health providers. Other studies have found that there is a relationship between distance from a

(...continued)

communicate with the MOH to learn what the recommended antibiotic, dosage, and treatment schedules are for pneumonia, and help limit the use of all antibiotics to the minimum necessary level.

facility and delays in seeking treatment (see Pneumonia Toolbox, Geographic Access module). If care seeking involves substantial costs in time or money, then child caretakers are unlikely to promptly seek care from appropriate health providers after recognizing signs of pneumonia. Caretakers may delay care seeking from trained health workers, and initially use home remedies or near-by untrained providers, and seek care from appropriate health workers only after initial treatment has failed or after signs of more severe disease are recognized. These delays in starting effective treatment for pneumonia will increase the risk of death.

Defining adequate access: Adequate access is defined by some sources as the population able to travel to a health provider in one hour or less, or those living within three to five kilometers of a provider. However, what "adequate access" means should be defined by each child survival program based on a good understanding of local conditions and care seeking practices.

Improving access: If much of the program site population does not have adequate access, then the child survival program should consider alternative strategies for increasing access, such as increasing the availability or reducing the cost of antibiotics, or increasing the number of health workers who can and do provide standard case management services.

Community Health Workers: Antibiotic treatment through community health workers is an appropriate way of increasing access to case management, if this approach is sustainable and approved by the MOH. Several intervention trials involving CHWs in pneumonia treatment and education of caretakers have documented the feasibility of this approach and have shown that this can have a substantial impact on under-five mortality. Most of these studies were conducted in areas with poor access to case management services at first level health facilities (see references). The successful treatment of childhood pneumonia by CHWs is also likely to increase CHW motivation and credibility. Thus, if child survival interventions are being phased-in over time, it may be a good idea to introduce pneumonia case management early in the life of a project. However, providing quality case management services through large numbers of CHWs may be expensive, difficult to sustain, not very replicable, and unattractive to the MOH. Thus, involving as few CHWs as are required to provide adequate access for the population to case management services, is likely to be the most appropriate approach. PCM algorithms and training materials designed for CHWs (see references) are likely to be more suitable for this level of

health worker than those designed for health facility clinicians.

If access will remain poor: If much of the project population does not have adequate access to case management services for pneumonia, and it is not feasible to substantially improve access to SCM over the course of the project, then PCM may not be a good choice for an intervention to be supported through the child survival program.

Prompt Care Seeking

Community-wide education: The focus of widespread communication about pneumonia (or ARI) should be on:

- Prompt recognition of signs of pneumonia by child caretakers,
- Prompt care seeking, and
- Identification of the specific health worker or facility from which care should be sought (and days/times of day care is available).

Importance of prompt care seeking: Pneumonia-associated deaths in older infants and children may occur within two to four days of the onset of lower respiratory signs. Although most children with signs of pneumonia will recover without treatment, delays in recognition or care seeking from appropriate health providers are important causes of high pneumonia mortality in many areas. Thus, education of household members to recognize the signs of pneumonia and to promptly seek care from specifically identified health workers is an essential component of the PCM intervention.

Young infants: Because over 30% of pneumonia-associated deaths in children under five occur within the first two months of life, and because the progression of illness in fatal episodes is likely to be particularly rapid in young infants, it is important for programs to design effective strategies and messages about recognition and care seeking for young infants. Caretakers must be reached before, or within a few days after, the birth of the infant. Because the signs of pneumonia in young infants are different than those in older infants and children, messages about recognition should be designed specifically for this age group. "Stopped feeding well" or "breastfeeding poorly" is an important sign to teach mothers to seek care for in a young infant (in addition to difficult breathing, and cough or cold with fast breathing). If in-patient care is not feasible, then young infants may be treated at home with oral antibiotics.

Preconditions for education: Community-wide educational activities regarding recognition and care seeking are appropriate only after (or in areas where) the population has adequate access to SCM. Education of caretakers should follow qualitative (ethnographic) investigations of local beliefs, practices, and vocabulary related to pneumonia recognition and care seeking,

with regard to both young infants and older infants/children.
CHWs may be a good initial source of this kind of information.

⊗ Home Care for ARI and Prevention of Pneumonia? ⊗

How important is home care for ARI? The role and importance of home care in ARI/pneumonia interventions is fundamentally different than in the control of diarrheal disease. In CDD, many cases of dehydration and diarrhea-associated malnutrition can be prevented by the use of home available fluids and proper feeding in the home. Thus, many diarrhea-associated deaths can be prevented in the home without care seeking from health workers. This is NOT the case for pneumonia. There is no convincing evidence that home care for children with upper respiratory infections can prevent pneumonia, or that home care without antibiotics for children with pneumonia can reduce the risk of death. To appropriately treat pneumonia, a caretaker must go outside the home to obtain antibiotics from a health worker.

When should education about home care be given? Counselling about home care (continuing to breastfeed, feed fluids and food, and keeping the young infant warm) is a component of pneumonia case management. WHO case management guidelines include messages about home care for ARI or pneumonia, for health workers to discuss with caretakers after an infant/child has been assessed for pneumonia. Messages about home care need not be a focus of community-wide educational activities, unless specific harmful practices in the community need to be addressed. A risk of focussing on home care for ARI in community-wide educational activities is that this may result in some caretakers delaying care seeking, while hoping that continued home care may cure the pneumonia, especially if seeking and using care from appropriate health providers is time consuming or expensive, as is often the case. PVOs may wish to include messages about continued feeding and fluids for all ill children (rather than for children with ARI) in their community-wide educational activities, in addition to specific messages about pneumonia recognition and care seeking.

What is the role of prevention? For pneumonia, specific interventions to reduce incidence or mortality remain unproven or very expensive. The *Hemophilus influenzae* type b (Hib) vaccine is very effective, but remains too expensive for most child survival program settings. Although there is a lot of evidence of a causal association between indoor smoke and childhood pneumonia, there is no convincing evidence so far that interventions to reduce indoor pollution will reduce either childhood pneumonia incidence or mortality, or that communication for behavior change can reduce exposure to smoke. Thus, the WHO Division of Child Health and Development still considers smoke and pneumonia to be an

important research issue, rather than a focus for intervention activities.⁸ More general preventive child survival interventions, such as measles and pertussis immunization, breastfeeding promotion, and nutrition interventions, may reduce the incidence of pneumonia. However, these interventions, if implemented, should be promoted for their more general benefits in reducing illness and death due to all causes, rather than just as components of a pneumonia intervention.

Conclusion: The major impact of pneumonia intervention activities on mortality will be achieved through prompt and effective treatment of pneumonia episodes, rather than through attempts to prevent pneumonia or provide home care for ARI. Thus, the focus of community-wide educational activities about pneumonia (or ARI) should be on prompt recognition of signs of pneumonia, and prompt care seeking, and NOT on home care or prevention.

⁸ Smoke and pneumonia: According to the WHO CHD Interim Programme Report 1996, Part II: Family and Community Practices, Section 5. INDOOR AIR POLLUTION: "The review of interventions to prevent pneumonia, reported in 1995, suggested that indoor air pollution was an area in which further information was needed to establish the level of reduction in air pollutants required to achieve a significant impact on pneumonia. Because reducing indoor air pollution might also have benefits in terms of the prevalence of low birth weight, interventions to reduce indoor air pollution could have a significant impact in reducing pneumonia morbidity and mortality in areas where it is a problem. Research on this issue is recognized as a priority by CHD but funds for its support have been limited. Efforts initiated by CDR in 1992 have been continued by CHD in order to obtain the resources required to support the implementation of the required intervention trial in at least one site."

The February 1998 Environmental Health Project report, Indicators for Programs to Prevent Diarrheal Disease, Malaria, and Acute Respiratory Infections, notes: "There is growing evidence that indoor air pollution is an important risk factor for ARI." "An approach to ARI prevention that focuses solely on improved chimneys and stoves and use of cleaner fuel is not sufficient. The kinds of improved chimneys and stoves introduced so far will decrease exposure, but not enough, and in many cases, these interventions have not been sustainable." "Need for Further Study. There is a lack of fundamental information, such as the dose-response relationship between particulate matter and ARI." "Behavior Change. For ARI it is still unclear whether or not behavior changes - particularly of mothers and caretakers - offer opportunity to reduce exposure. For example, does it make sense to encourage mothers to leave their children in another room when they are cooking? The issue of child safety is complicated. Incidence of ARI is highest in the first six months of life. We should not promote behavior changes that would separate mothers and children at a key time in a child's life, especially given the fact that behavior change may be at the margin."

References for Implementing Pneumonia Case Management

1. The Management of Acute Respiratory Infections in Children: Practical Guidelines for Outpatient Care. WHO, 1995. Case management guidelines for staff managing children with ARI in first-level health facilities and their supervisors.
2. Outpatient Management of Young Children with ARI: A Four Day Clinical Course. WHO, 1992. A package for training physicians, nurses, nurses' assistants, and other health center staff.
3. Management of Childhood Illness, WHO and UNICEF, 1995. The IMCI charts and manuals for health facility clinicians include the same basic algorithm for pneumonia in older infants and children as the WHO ARI documents for outpatient facilities (references 1 and 2 above). However, the IMCI materials include a more complex algorithm for "possible serious bacterial infection" in young infants instead of the simpler more pneumonia-specific algorithm in the ARI documents. The IMCI materials also address the overlap in the clinical presentation and treatment of malaria and pneumonia in more detail, and exclude the management of wheezing.
4. Treating Children with a Cough or Difficult Breathing: A Course for Community Health Workers. WHO, 1992. This package includes: An ARI Programme Manager's Guide, A Course Director's Guide, A Teacher's Guide, Learner's Materials, and a video of pneumonia signs. The simplified algorithm in these documents addresses the overlap in the clinical presentation and treatment of malaria and pneumonia, but is more appropriate for CHWs than the complex ARI or IMCI algorithms for clinicians.
5. Acute Respiratory Infections in Children: Case Management in Small Hospitals in Developing Countries: A Manual for Doctors and Other Senior Health Workers. WHO, 1990 (WHO/ARI/90.5).
6. Pneumonia Care Assessment Methods Toolbox. The Johns Hopkins University PVO Child Survival Support Program, 1998. These materials were designed for PVO CS programs to assess the quality of pneumonia case management services and local pneumonia related beliefs, practices, and vocabulary. The health facility/worker assessment methods and qualitative/ethnographic approaches described in the toolbox were adapted for use at the program site level from the WHO ARI Programme Health Facility Survey and Focussed Ethnographic Survey.
7. Murray J, Manoncourt S. Use of an Integrated Health Facility Assessment for Planning Maternal and Child Health Programs: Results from Four African Countries. Published for USAID by the BASICS Project, 1998.

8. PVO Child Survival Technical Report, Volume 5, Number 1. The Johns Hopkins University PVO Child Survival Support Program, April 1997. This issue is devoted to ARI/PCM.

Scientific Basis of Pneumonia Case Management

9. Technical Bases for the WHO Recommendations on the Management of Pneumonia in Children at First-Level Health Facilities. WHO, 1991 (WHO/ARI/91.20).

10. The Overlap in the Clinical Presentation and Treatment of Malaria and Pneumonia in Children: Report of a Meeting. WHO, 1992 (WHO/ARI/92.23).

11. Sazawal S, Black RE. Meta-Analysis of Intervention Trials on Case-Management of Pneumonia in Community Settings. Lancet 1992; 340: 528-33. Focuses on the mortality impact of PCM trials, mostly using CHWs. Includes references for the original papers concerning nine different studies in developing countries.

12. Case Management of Acute Respiratory Infections in Children: Intervention Studies. Report of a Meeting. WHO, 1988 (WHO/ARI/88.2). Similar to the above document, includes more discussion of programmatic issues, but excludes recent trials.

13. CHD 1996-1997 Report, Division of Child Health and Development, WHO, 1998. CHD publishes a program report every year which reviews important developments in ARI, IMCI, and CDD. The CHD Interim Programme Report 1996 is on CHD's website.

Internet Reference/Ordering Documents from WHO

Most of the WHO documents cited above are available in English on the worldwide web at: <http://www.who.ch/chd/pub/catalog.htm>. This website of the WHO Division of Child Health and Development (CHD) also contains an extensive reference list of WHO ARI and IMCI documents, many of which are available in English, French, and Spanish from: The Director, Division of Child Health and Development, World Health Organization, CH-1211 Geneva 27, Switzerland (fax: +41 (22) 791-4853 or 791-0746, e-mail: WESSELL@who.ch). Some of these WHO documents may have been adapted for use in your country by the MOH.

⊗ Reference Materials Which Are NOT Recommended ⊗

"Facts for Life" is NOT recommended as a source of messages for parents on pneumonia, for PVO child survival programs.

Plasmodium falciparum, the parasite responsible for most malaria-associated deaths, affects children in three ways: acute malaria illness, chronic or persistent malaria parasitemia with anemia, and perinatal malaria infection in the mother, which can cause low birth weight and increased infant mortality. Malaria interventions are appropriate for areas where the disease makes a substantial contribution to under-five mortality. The goal of the malaria intervention is to reduce malaria associated mortality and morbidity in children and pregnant women. PVOs implementing a malaria intervention may include any or all of the following approaches to malaria control in their programs:

- Improved Malaria Case Management (MCM);
- Antenatal prevention and treatment of malaria; and
- Reduction in malaria transmission through the community-wide use of insecticide-treated mosquito nets, including provision for regular re-treatment of the nets.

Activities that are beyond the scope of the PVO Child Survival Grants Program include large-scale insecticide spraying operations or environmental engineering measures, and community-wide administration of antimalarial drugs, including mass chemoprophylaxis for children. Environmental measures, such as clearing of brush and filling in ponds and ditches around houses, have only limited effectiveness.

Malaria Case Management

Malaria Case Management is an essential component of an effective malaria control program. The requirements for a successful MCM intervention are the same as those for pneumonia case management:

- quality case management,
- adequate access, and
- essential household actions.

Providers of antimalarial drugs (including shop owners, drug peddlers, and health personnel) should:

- provide a full course of an appropriate drug,
- provide information on correct drug use, and
- refer children with signs of severe disease to health facilities.

Facility-based health personnel should:

- diagnose and treat malaria promptly with an effective antimalarial drug,
- provide supportive care,
- provide treatment of anemia,
- provide effective patient education, and
- refer cases of severe disease, where appropriate.

Essential actions in the home include:

- early recognition and care-seeking for episodes of fever,
- completion of a full course of treatment, and
- further care-seeking if the child develops signs of severe disease.

The overlapping clinical presentation of malaria and pneumonia is an important consideration in all areas where children are treated for malaria. Epidemiological studies conducted in several settings in Africa indicate that a substantial proportion of children with fever will also meet a pneumonia case definition (cough or difficult breathing, and fast breathing or chest indrawing), and that almost all children meeting a pneumonia case definition also have fever or a history of fever. Treatments for malaria alone may result in death from pneumonia. Thus, all malaria protocols for children at the community, drug retailer, and health facility levels should incorporate case management for pneumonia (unless it is not possible to do so). Alternative strategies for incorporating pneumonia into malaria protocols include:

- Training, supplying, and supervising health providers to assess for and treat pneumonia, as well as malaria (ie., also doing a pneumonia case management intervention); or
- Training providers to assess for pneumonia (including measuring for fast breathing and looking for chest indrawing in all children with cough or difficult breathing), and referring children with signs of pneumonia for treatment by another provider (which is only appropriate if caretakers have access to quality pneumonia treatment services); or
- Training providers to ask whether a child has cough or difficult breathing in all cases when doing malaria case management, and referring all cases of cough or difficult breathing to another provider for assessment for pneumonia (an approach which will result in referring many children, and which is only appropriate if caretakers have access to quality pneumonia case management services).

Antenatal Prevention and Treatment

Antenatal prevention and treatment of malaria may increase birth weights and reduce maternal and fetal morbidity and mortality. Women who are pregnant for the first time are at greatest risk for complications arising from malaria. They also might not attend antenatal services as frequently as other pregnant women, especially if they are unmarried or very young.

Weekly chloroquine prophylaxis is no longer effective in many countries because of the increasing prevalence of chloroquine resistant strains of *P. falciparum*. Where there is widespread drug resistance, an alternative treatment protocol should be selected in consultation with the Ministry of Health. For example, in Malawi the Ministry of Health now recommends the administration of a full course of treatment with pyrimethamine - sulfadoxine (Fansidar) twice during pregnancy.

Insecticide-Treated Mosquito Nets

Trials of insecticide-treated bednets conducted recently in East and West Africa have demonstrated that this simple technology can reduce all-cause mortality in one to 59 month old children. These were mainly controlled trials in which bednets and insecticide were distributed for free. How effective bednets and other insecticide-treated materials, such as curtains, would be under conditions of voluntary acquisition and use is less clear.

Experience has shown that, to be successful, bednet programs must create conditions for sustained public demand for, access to, and appropriate use of affordable nets and insecticides to treat them:

- Public demand: At present, public demand for bednets and other insecticide-treated materials varies throughout Africa. Mosquitoes are often not recognized as the cause of malaria. Bednets have high acceptability in many communities as a defense against nuisance bites, not as a malaria prevention. Insecticide treatment of bednets and curtains as a prevention for malaria is a recent strategy and is not widely disseminated.
- Access: Bednets are generally available only in urban areas, if they are available at all, and no organized public or private systems exist for delivery of insecticide services.
- Affordability: In many places, bednets currently cost \$10 to \$25, and insecticide treatments

- Appropriate use: \$1 to \$2 per year. The typical household may require up to three or four bednets. This means that the use of insecticide-treated bednets could be unaffordable for most households. Bednet programs cannot be successful unless a number of ingrained behavioral and social patterns change. Without such changes, it is unlikely that the right populations will use the nets and use them correctly. For example, young children may not have priority for use of bednets within households. To be effective bednet programs should be designed in accordance with local beliefs and social patterns to encourage bednet use by young children and pregnant women.

More difficult than provision of nets themselves, but of critical importance, are systems for insecticide re-treatment. Thus, PVOs should consider implementing insecticide-treated mosquito net activities only when it is likely that a sustainable program of net provision and re-treatment can be set up. When nets and insecticide are initially distributed for free, usage may drop dramatically after charges are introduced. There is evidence in Gambia, however, that usage begins to resume after a period of time. PVOs should consider a charge, however nominal, when initiating bednet programs.

Nets that are regularly treated with a pyrethroid insecticide have been shown to be far more effective than untreated nets. This is because of the repellent and insecticidal effects of the insecticide, and because torn and damaged nets still provide protection if they have been treated with insecticide. Therefore, programs should not promote the use of untreated nets. Cotton nets are not suitable for insecticide treatment because the insecticide is absorbed into the interior of the fiber.

In countries where use of untreated mosquito nets is already high, programs may only need to introduce insecticide treatment of nets. If malaria transmission is confined to only part of the year, it may be possible to treat the nets once a year instead of every six months.

Recommended General References on Malaria Control

1. Child Health Dialogue (published by AHRTAG) issue 6. This 16-page issue with a supplement on malaria contains

information on prevention, recognition and management of malaria in young children and pregnant women. Contact: Mary Helena, Publications Secretary, AHRTAG, 29-35 Farringdon Road, London EC1M 3JB. Tel: +44 171 2420606, Fax: +44 171 2420041, Email: ahrtag@gn.apc.org, Internet: <http://www.poptel.org.uk/ahrtag/> For the electronic version of CHD contact: hnet@usa.healthnet.org

2. Global Malaria Control Strategy. PVO Child Survival Technical Report, Vol.4, No. 1, January 1994. This document contains several helpful references.

Recommended References on Specific Aspects

Malaria Case Management and Drug Resistance

3. Management of Childhood Illness, WHO Division of Child Health and Development, and UNICEF, 1995. The IMCI charts and manuals for health facility clinicians include guidelines for the management of fever in areas of low and high malaria risk, and address the overlap of malaria and pneumonia.

4. The Overlap in the Clinical Presentation and Treatment of Malaria and Pneumonia in Children: Report of a Meeting. World Health Organization, Malaria Unit, 1992 (WHO/MAL/92.1065).

5. Breman J. G., Campbell C. C. Combating severe malaria in African children. Bulletin of the World Health Organization. 1988; 66(5): 611-620.

6. Ofori-Adjei D., Arhinful D.K. Effect of training on the clinical management of malaria by medical assistants in Ghana. Social Science and Medicine. 1996; 42(8): 1169-1176.

Antenatal Prevention and Control of Malaria

7. Steketee, R., Wirima, J. Malaria Prevention in Pregnancy: The Effects of Treatment and Chemoprophylaxis on Placental Malaria Infection, Low Birth Weight, and Fetal Infant and Child Survival, American Journal of Tropical Medicine and Hygiene, 55: 1 Suppl. (1996): Entire volume (16 articles).

8. Helitzer-Allen H.L., Macheso A., Wirima J., Kendall C. Testing strategies to increase use of chloroquine chemoprophylaxis during pregnancy in Malawi. Acta Tropica. 1994; 58: 255-266.

Insecticide-Treated Mosquito Nets

9. Bermejo A, Veeken H. Insecticide-impregnated bed nets for malaria control: a review of the field trials. Bulletin of the World Health Organization 1992; 70: 293-296.

10. Choi HW, Breman JG, Teutsch SM, Liu S, Hightower, AW, and Sexton JD. The effectiveness of insecticide-impregnated bed nets in reducing cases of malaria infection: a meta-analysis of

published results. American Journal of Tropical Medicine and Hygiene. 1995; 52: 377-382.

11. Curtis C.F., Myamba J., Wilkes T.J. Comparison of different insecticides and fabrics for anti-mosquito bednets and curtains. 1996; 10: 1-11.

12. Lengeler C, Cattani J and de Savigny D (Eds.) Net Gain: Operational Aspects of a New Health Intervention for Preventing Malaria Death. Geneva: World Health Organization/TDR and Ottawa: International Development Research Centre.

13. Makemba, A., Winch, P.J., Kamazima, S., Makame, V., Semngo, F., Lubega, P., Minjas, J., and Shiff, C. Community-based sale, distribution and insecticide impregnation of mosquito nets in Bagamoyo District, Tanzania. Health Policy and Planning, 1995: 10; 50-59.

14. Winch, P.J., Makemba, A.M., Kamazima, S.R, Lurie, M., Lwihula, G.K, Premji, A., Minjas, J.N. and Shiff, C.J. Local terminology for febrile illnesses in Bagamoyo District, Tanzania, and its impact on the design of a community based malaria control programme. Social Science and Medicine, 1996: 42; 1057-1067.

15. Insecticide Treated Nets for Malaria Control: A directory of suppliers of insecticides and mosquito nets for sub-Saharan Africa. AHRTAG, 1997. Includes: practical information on the preparation and use of treated mosquito nets; suppliers of finished nets, bulk netting, insecticides and related products for malaria control; and a list of useful contacts and resource materials. Single copies free of charge (see reference 1).

Internet References

The Environmental Health Project Website with Links to several malaria topics, including bednets:
<http://www.access.digex.net/~ehp/webliog.html>. Homepage is:
<http://www.access.digex.net/~ehp>.

Safe maternal and newborn care is part of a comprehensive child survival program, ensuring that women can go safely through pregnancy and childbirth and have a healthy infant. While pregnancy is usually a healthy state and most births proceed without difficulty, some women suffer life threatening complications that result in the death of the mother, the infant, or both. Many women who do not die suffer debilitating illnesses and injuries from complications during pregnancy. As a child survival intervention, maternal and newborn care promotes the survival of the infant directly, and indirectly through the survival of the mother.

One organization probably could not provide all the key elements needed to reduce maternal mortality. It will take multifaceted programs designed to address several contributing factors, and coordinated efforts of country governments, indigenous NGOs, international NGOs, bilateral and multilateral donor agencies, and the private sector to address the worldwide problem of maternal mortality, maternal morbidity, and newborn deaths. Community level programs can significantly contribute to reducing maternal and newborn mortality by focusing their IEC efforts on complications and referral, birth planning, clean births, post-partum care, and newborn care.

Approximately 15 percent of all pregnant women will require some form of emergency obstetrical care, including surgical intervention. However, predicting which women will need these services is difficult. Worldwide, about a quarter of all maternal deaths occur during pregnancy, only 16 percent of maternal deaths occur during delivery, and the majority of maternal deaths (60%) occurs postpartum (within 42 days of birth).

Almost two thirds of newborn (within the first month of life) deaths are from some type of infection (sepsis, tetanus, pneumonia and diarrhea), while a third of deaths are related to birth trauma and asphyxia during birth. Contributing to the fragility of the infant is low birth weight (LBW), which is directly related to the health of the mother before and during pregnancy. Low birth weight is the most significant predictor for survival of the baby, and for health, growth, and development. Mortality is much higher among LBW infants. Common life-threatening problems that occur in LBW babies are hypothermia, infection, and respiratory distress. Other important problems in the newborn period include stillbirths from maternal syphilis infection, and blindness from maternal gonorrhea or chlamydia infection.

A strong maternal/newborn care program will include improving maternal health during pregnancy, enhancing the identification and management of complications during and after birth, and improving the quality of newborn care. The program

will be most effective if it relates to programs that delay and prevent untimely pregnancies.

Preconception

Programs that will positively affect maternal and newborn health and survival include but are not limited to health education and counseling on reproduction, access to child spacing services, improvement of women's nutrition, especially addressing anemia, and increasing vitamin A stores, identification and treatment of sexually transmitted infections (STI) and reproductive tract infections (RTI), and development of community systems for support of mothers. Clearly, quality of care in these services, and ensuring availability of referral services contribute to the success of a program. Family planning alone could prevent at least 25% of maternal mortality. Child spacing/family planning, nutrition, and STI/HIV interventions are addressed in other chapters of this Technical Reference.

Prenatal Care

Prenatal care is beneficial because it is associated with a better overall pregnancy outcome for both mother and infant. However, the effectiveness of prenatal care in reducing maternal deaths is not well documented. In fact, no single component of prenatal care has been proven to reduce maternal deaths.⁹ Prenatal care for pregnant women can help prevent factors associated with newborn mortality such as low birth weight, tetanus, and complications from malaria during pregnancy. Essential prenatal care to reduce newborn mortality includes educating the mother, and birth attendants (nurse/midwives, TBAs), about the care of newborns (see below). In addition, programs may wish to provide education regarding maternal nutrition (see Nutrition and Breast-feeding sections). Programs can promote, provide directly, or support other antenatal care activities.

Prenatal care can reinforce those aspects of the pregnancy that are progressing well, and prepare the mother, other family members, and birth attendants (all levels) for possible emergencies. Prenatal care is potentially most effective for prevention and treatment of maternal anemia; detection and treatment of maternal infections, especially STIs and other reproductive tract infections; and providing an opportunity for contact with pregnant women to provide health education and promote self care. Major elements of prenatal care include:

⁹ Safe Motherhood Training Package, UNICEF. 1994. Participants Manual, Session 5: Addressing the direct causes of maternal mortality, page 7.

- birth preparedness planning with mother, family, and community, including counseling on recognition of danger signs (bleeding, convulsions, palor, labored breathing, headache, swollen hands and feet, fever), and where, when, and how to obtain referral care;
- early detection and management of pregnancy related problems such as anemia, preeclampsia, STIs, or malaria, or chemoprophylaxis or periodic treatment for malaria in malarious areas (see Malaria section);
- provision of preventive care, especially maternal tetanus immunization and iron/folate supplementation;
- promotion of healthy behaviors and social support for behavior change, including: reduced workload, rest, hygiene, nutrition and iron/folate supplementation and other treatments, and additional care or referral; benefits of attended birth and safe delivery techniques; immediate and exclusive breast-feeding; post partum child spacing; and reduction in harmful practices;
- community planning and support for routine and emergency communication and transport; and promotion of use of maternity waiting homes or other alternative birth locations; and
- when possible, monitoring pregnancy progress, including maternal weight gain(9-18kg) and hemoglobin status, blood pressure, proteinuria and fundal height.

Prenatal Risk Screening

Most screening programs for risk factors for obstetric emergencies are not able to correctly identify which women need specialized obstetrical services. Most obstetric complications and deaths occur in women who have no risk factors, and most mothers with the risk factor(s) will not experience an obstetric complication. Risk factors with higher predictive value usually present toward the end of pregnancy, often allowing inadequate time for referral and treatment. Risk screening should address only those few risk factors for which the project has concrete and appropriate interventions available. For example, screening for risk factors for caesarian section is useful only in areas where caesarian section is available. Screening for hypertension as an indicator of pre-eclampsia is useful in areas where pregnant mothers can be monitored, and where appropriate medications are available.

Childbirth

Safe, clean childbirth care should be available to all women during labor and delivery. More than 60 percent of births in developing countries occur at home, and 45% of those are with

no trained birth attendant. Traditional Birth Attendants (TBAs) have an important role in childbirth but they cannot, by themselves, reduce maternal mortality without appropriate linkages/back-up services to address complications as they arise. Trained birth assistance can reduce the incidence, improve the outcome, or allow early recognition and referral, of certain complications of childbirth, such as hemorrhage, prolonged labor, infection, and preeclampsia in women. The greatest potential impact of safe, clean birth care is through the prevention of infection and postpartum hemorrhage. At all levels of birth attendants, a program can reinforce the principles of a "Mother Friendly" labor and birth, that create a woman-centered, sensitive, and caring environment, and allow for eating, drinking, walking, and close family support in labor. Essential care for prevention of maternal deaths for deliveries attended by family members and traditional birth attendants includes:

- promotion of the three cleans: clean hands of the birth attendant; clean cutting of the umbilical cord; clean delivery surface (some sources recommend six, adding clean water and soap, clean string to tie the cord, and clean cloths to wrap the baby and for the mother - some programs use sanitary pads);
- use of safe birth kits with materials for using safe birth techniques;
- recognition of, and timely, appropriate action for obstetric danger signs, such as prolonged labor (over 12 hours), excessive blood loss, fever, chills, discharge, malpresentation, a retained placenta;
- assessing and discouraging harmful practices, such as oxytocin use during labor, internal exams in labor, or rough fundal massage;
- immediate breast-feeding; and
- adequate newborn care: immediate warming, drying, stimulation of crying, and ensuring the baby's airway is clear.

Child Survival programs can provide training in essential childbirth care to those providing delivery services in the project area (nurse/midwives, TBAs). Programs can also educate families and communities about essential childbirth care, especially in areas where babies are born in the home.

Complications during and after child birth

All pregnant women are at risk for obstetric emergencies, particularly hemorrhage. Emergency obstetric care (EmOC) prevents maternal deaths by promptly providing essential care to a woman

with an obstetric emergency. The fundamental components of emergency obstetric care are:

- Prompt Care-Seeking: Prompt recognition of danger signs and deciding to seek care;
- Adequate Access: Access and transport of all women to quality emergency obstetric care.
- Community Obstetric First Aid: Community health workers and TBA effectively trained and supervised in life-saving skills; and
- Quality EmOC: Health providers effectively trained and supervised in emergency obstetric care, with adequate facilities, equipment, and supplies.

Prompt Care-Seeking

Factors that affect a woman and her family's decision to seek care include not only the understanding of danger signs, but also the decision-making processes in the household, traditional beliefs, traditional unattended home birthing practices, low knowledge of causes of death, and a poor perception of the health facilities. To improve prompt care-seeking for complications, programs can identify the barriers, educate families and train care providers (nurse/midwives and/or TBAs) to recognize, manage, and/or refer complications, and to counsel mothers about danger signs needing immediate care and the specific facilities that provide that care. Preparation for possible emergencies includes at least encouraging pregnant women to participate in prenatal care, educating communities about danger signs that indicate obstetric complications needing immediate care, and identifying the specific health facility that provides quality, accessible care.

Adequate Access

Lack of access to emergency care may be due to financial barriers, long traveling times to the closest referral site, and difficulty in obtaining transport. The woman, family, and/or TBA may not know where to go, how to contact a transport worker, or transport may not be willing to take the woman, or may be too costly. To assure adequate access of the beneficiary population to quality emergency obstetric care services, program staff can work with communities to develop a transport/referral system from each community in the project area to a facility providing

emergency obstetric care. Solutions developed by community members themselves are more appropriate and sustainable, and once a transport/referral system is in place, communities can monitor the functioning of that system. Reducing cultural or religious barriers can also improve access.

Obstetric First Aid in the Community

Community health workers and TBAs can be trained in basic life-saving skills such as uterine massage, bi-manual compression, ORS, postpartum nasal/sub-lingual oxytocics, and to recognize problems for referral. They can be instrumental in organizing communities for transport, and for interface with the formal health facilities.

Quality Emergency Obstetric Care

The essentials of obstetric care, as defined by WHO, include IV fluids, antibiotics, anti-convulsants, oxytocics, manual removal of a retained placenta, and assisted vaginal deliveries. More comprehensive services include, blood transfusion, anaesthesia, and Caesarean section. To improve quality of emergency obstetric care, child survival programs can collaborate with the MOH in assessing the capacity of facilities to provide emergency obstetric care (that providers at designated facilities are adequately trained and supervised, and essential facilities, equipment, drugs and supplies are available) and cooperate in follow-up actions to correct any identified problems. Where appropriate, PVOs may also train staff to monitor the quality of emergency obstetric care regularly, to ensure that essential systems that support EmOC are operational.

Additionally, community programs can help to improve the maternal care environment. Programs can try to insure that the mother is informed about her choices of all procedures and treatments, and that services are provided by an appropriate health worker in a way that maintains a woman's dignity and respects her modesty.

Postpartum Care

Most maternal deaths occur in the postpartum period. Nearly half (45%) of postpartum deaths occur within the first 24 hours after delivery, more than 65% of postpartum deaths occur in the first week after delivery, and 80% of deaths occur within two weeks, with the remainder occurring until six weeks postpartum. In developing countries the percentage of postpartum deaths occurring in the first week may be as high as 80 percent. These data have clear implications for better postpartum care. However, fewer women receive care after delivery than any other type of maternal care. Important elements of routine postpartum care include:

- monitor the mother for 48 hours
- early detection, referral, and treatment of maternal infection or hemorrhage,
- promotion and provision of family planning,
- breast-feeding support;
- education about hygiene, nutrition, and infant care;
- high dose vitamin A to mothers within the first eight weeks after delivery (see Micronutrient section)
- iron/folate therapy in cases of moderate to severe postpartum anemia (see Micronutrient section).

Ideally, postpartum visits will take place during the first 48 hours, then one week after birth, at three weeks, and again at six weeks. Essential newborn postpartum care to prevent mortality during the first week of life includes attention to breathing, prophylactic eye care, BCG and OPV, exclusive and frequent breast-feeding, cord care, and keeping the baby warm (including "kangaroo" care for small or premature infants). Programs can educate mothers and families to recognize danger signs in neonates and promptly provide and/or seek appropriate care. Postpartum care does not need to be based in a health facility. With appropriate training, nurses, TBAs, and other health workers can provide basic postpartum care at home in many countries. Programs can include these elements of essential care when training those who provide delivery services (nurse/midwives, TBAs), and during education sessions with mothers and families.

Highly Recommended Reference Materials

1. Mother Baby Package: Implementing Safe Motherhood in Countries. WHO, 1994. This practical guide for the implementation of maternal and newborn care activities includes a broad range of potential maternal care activities (many appropriate for very rural and isolated settings) with corresponding objectives and

strategies for achieving the objectives. Includes a complete WHO Safe Motherhood Resource list.

2. Safe Motherhood Training Package, UNICEF. 1994. Participants Manual, Session 5: Addressing the direct causes of maternal mortality, pages 1 - 32, and Participants Manual, Reading 5.1: Approach to prevention of maternal deaths by setting, pages 1-10 (a reading excerpted from: Programming for Safe Motherhood, chapter 5, Koblinsky et. al., World Bank, 1992). Much of the technical guidance in this section comes from this UNICEF training package.

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6. Klein S. A Book for Midwives A Manual for Traditional Birth Attendants and Community Midwives. The Hesperian Foundation, 1995.

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10. Anderson F. 1994. "Lowering Maternal Deaths". PVO Child Survival Technical Report. 4(2): 30-31. Available from JHU PVO CSSP.

11. Mothers and Child Survival: Lessons Learned in Adding Maternal Health Interventions to PVO Child Survival Projects. This publication includes recommendations from the 1992 PVO Maternal Lessons Learned Conference in Shiprock, New Mexico.

12. A Review of Maternal Care Messages and Curricula Used in PVO Child Survival Projects. The Johns Hopkins University Child Survival Support Program, May 1995. This document contains a bibliography with 12 references appropriate for PVO child

survival programs. Major areas of concern identified in this recent review include: the lack of distinction between danger signs and risk conditions, the lack of concrete follow-up actions when problems are identified, care of the newborn and postnatal care, and the failure of programs to evaluate maternal care training programs and the quality and content of messages for mothers.

13. Training of Traditional Birth Attendants (TBAs). WHO. Includes a guide for master trainers, a guide for TBA trainers, and an illustrated guide for TBAs.

14. The Warmi Project: A Participatory Approach to Improve Maternal and Neonatal Health, An Implementors Manual. The Mothercare Project.

15. Management of Obstetric and Neonatal Emergencies in Community Health Centers. The Mothercare Project.

16. Training Manual for Trainers of Traditional Birth Attendants. The Mothercare Project.

17. Life-Saving Skills Manual for Midwives. Third Edition, October 1997, The American College of Nurse-Midwives. Much expanded and thoroughly revised edition.

18. Life-Saving Skills Manual for Policy Makers and Trainers. First Edition, October 1997, The American College of Nurse-Midwives.

19. Management of Life Threatening Obstetrical Emergencies. The Mothercare Project.

20. Obstetric Management Protocols for Regional-Departmental Hospitals. The Mothercare Project.

21. Maternity Waiting Homes: A Review of Experiences. WHO/FRH/MSM/96.24.

22. Verbal Autopsies for Maternal Deaths. WHO/FRH/MSM/95.15.

References 1, 13, 21, 22, and other safe motherhood materials, are available free of charge from the Division of Family Health, WHO, 1211 Geneva 27, Switzerland. Tel.: 41 (22) 791-2111. Fax: 41 (22) 791-0746. Telex: 27821.

References 5, 10, 11, and 12 are available from the PVO Child Survival Support Program, 103 East Mt. Royal Ave., Baltimore, MD 21202. Tel.: (410) 659-4100.

The Mothercare Project/John Snow Inc. has published references 8, 14, 15, 16, 19, 20, and many other excellent monographs and training manuals appropriate for PVOs to use in strengthening community involvement and training, and improving quality of care. These are available from

MATERNAL AND NEWBORN CARE

Mothercare, 1616 North Fort Myer Drive, 11th Floor,
Arlington VA, 22209. Tel.: (703) 528-7474.

References 17 and 18 are published by the American College
of Nurse-Midwives, 818 Connecticut Ave., NW, Suite 900,
Washington D.C. 20006, Phone: 202-728-9864, Fax: 728-9896.

Internet References

MotherCare home page: <http://www.jsi/intl/mothercare>

MotherCare2 home page:

<http://www.midwife.org/prof/mcare2.htm>

The purpose of the child spacing intervention is to allow people in the program area to space pregnancies as far apart as they wish, and prevent unwanted pregnancies, thereby decreasing maternal and under-five mortality. PVOs are encouraged to work with existing providers in the program area to increase access and improve the quality of services. A quality family planning program comprises the following six key elements (Bruce, 1990):

- Choice of family planning methods (including availability of methods, variety of methods, and ease of referral). Choice refers to the number and range of methods offered. It provides choices for men and women who wish to space, limit, or cease, childbearing.
- Information and counseling given to clients. This refers to information given during the client visit, which enables clients to choose and use a method satisfactorily. It includes details on the range of methods, advantages and disadvantages, how to use the method selected, possible side effects, and the support clients can expect from the service provider.
- Technical competence (staff skills and training, availability and utilization of service protocols, availability of technical support, and level of hygiene and infection control). The clinical competence of the service provider, extent and adequacy/quality of training and supervision must be addressed.
- Interpersonal relations (client-provider communications, and respect, understanding, and truth shown to client). How clients feel about the attitudes of providers and the service they receive, as well as the competence of service providers in interpersonal relations is critical to continuing utilization.
- Mechanisms to encourage continuity (adequate client follow-up, information about return visits, and positive provider-client relationship). These are included in a program's ability to promote continued contraceptive use. It can rely on community media or follow-up mechanisms such as home visits by providers.
- Constellation (appropriateness and acceptability) of services (location, timing, privacy, variety, physical facilities, client flow and waiting time, staffing). Services should be convenient and acceptable to clients. Policies and procedures that create barriers to use, such as requirements for frequent revisits and excessive data collection, should be avoided. There is no one, ideal model; appropriateness varies according to the situation.

Regardless of specific program content/activities, it is important from the outset to plan who will be served, how many women, men, or couples, and with approximately what level of effort; all of which should be based upon a determination of unmet need in the program area. The unmet need is defined as the proportion of women or couples wishing to regulate their fertility but who are not currently practicing child spacing/family planning. To find out the unmet need requires talking to community members and undertaking baseline surveys regarding how many children potential clients now have; how many they want; current and desired spacing; what they know and do about family planning; their health and the health of their children. This baseline information is essential in order to establish appropriate targets, set realistic goals and objectives, and establish indicators which can be monitored and measured to identify implementation issues and determine ultimate success/effects of the program and specific interventions.

To ensure a successful child spacing program, it is important that contraceptive commodities be available in the right place at the right time and in the right quantities. A well-functioning contraceptive supply system is essential and, if not already established in the program area, must be addressed. Elements of this include:

- Forecasting contraceptive needs;
- Maintaining adequate supplies of contraceptives;
- Identifying contraceptive suppliers;
- Storing contraceptives; and
- Record keeping for contraceptive supplies.

Appropriate information, education and communication (IEC) are also essential to a successful child spacing/family planning program. Messages can be offered in many venues, including clinics, communities, schools, work places, and meetings. IEC messages communicated through visual, audio, or audio-visual materials, can dispel misinformation, clarify misperceptions and rumors, change negative attitudes, and encourage the use of a method which suits the client's needs. Good IEC:

- helps increase awareness;
- helps couples exercise their decision-making rights;
- encourages quality improvement and accessibility;
- improves attitudes and beliefs; and
- addresses important health behaviors.

For PVOs proposing the actual delivery of child spacing/family planning services, two service delivery models to

consider are community-based distribution (CBD) and clinic-based services. They can be used alone or in combination, depending on available resources and on community needs. A variation of these two basic service types is the mobile clinic that offers clinic-type services at regular intervals to remote communities. Mobile services can also support community-based distribution by offering a referral point and by resupplying Community-Based Distributors.

Programs should consider targeting those groups most in need of family planning, and/or those most likely to use the services. For example, women who have recently had a child and want no more children in the next two years, but who are not using modern contraceptives, may be effectively reached through post-natal visits. Men, newly married couples, and adolescents, might be considered as targets for specific IEC and service delivery. However, community mobilization efforts may need to address a large cross section of the local population to garner interest, support, and commitment, for child spacing/family planning interventions.

In summary, the key points in selecting a child spacing/family planning program strategy, that defines both the types of services to be offered and how they can be delivered most effectively, are:

- Defining the elements of high-quality services (including the importance of counseling and informed choice, together with the need for information, education, and communication, to establish good client interaction);
- Reviewing family planning services - what can be offered including IEC, counseling, contraceptive method services and referral;
- Comparing service delivery models (community-based, clinic-based, mobile services);
- Planning referral and clinical back-up services;
- Preparing a sustainable program - technical, financial, and organizational considerations; and
- Selecting a strategy - reviewing service delivery strategies and deciding upon the best approach for a given context.

Highly Recommended Reference Materials

1. Integrating Reproductive Health Into NGO Programs, Volume 1: Family Planning. Joyce V. Lyons and Jenny A. Huddart, Family Planning Service Expansion and Technical Support (SEATS) Project, 1996. John Snow, Inc. (SEATS/JSI, 1616 N. Fort Myer Drive, Suite 1100, Arlington, VA 22209).

2. Pocket Guide for Family Planning Service Providers, Paul D. Blumenthal and Noel McIntosh, JHPIEGO Corporation, 1995. (JHPIEGO, Brown's Warf, 1615 Thames St., Baltimore, MD 21231).

3. Family Planning Lessons and Challenges, Making Programs Work. Population Reports, Series J, No 40, August 1994. (The Johns Hopkins University Center for Communication Programs, 111 Market Place, Suite 310, Baltimore, MD 21202-4024).

4. Family Planning Counseling: Meeting Individual Client Needs. OUTLOOK. Volume 12, No. 1. May, 1995. (PATH, 1990 M St., NW, Suite 700, Washington, D.C. 20036).

5. Family Planning Logistics Guidelines, Centers for Disease Control and the Family Planning Logistics Management Project, John Snow, Inc., 1993. (JSI, FPLM Project, 1616 N. Fort Myer Dr., Suite 1100, Arlington, VA 22209).

Other Recommended Reference Materials

6. Family Planning Counseling: A Curriculum Prototype (Participants Handbook), AVSC International, 1995. (AVSC International, 79 Madison Ave., New York, NY 10016).
7. The Family Planning Managers's Handbook: Basic Skills and Tools for Managing Family Planning Programs, Wolff, J. A. et al., Management Sciences for Health, 1991. (FPMD Publications Unit, Management Sciences for Health, 400 Centre St., Newton, MA 02158).
8. Handbook of Indicators for Family Planning Program Evaluation, Bertrand, J.T. et al., The Evaluation Project, Chapel Hill, 1994. (The Evaluation Project, Carolina Population Center, CB #8120, University of North Carolina, Chapel Hill, NC 27516).
9. Mauldin WP, and Sinding SW. Review of Existing Family Planning Policies and Programs: Lessons Learned. Population Council, New York, 1993. (working paper No 50, 49 p.), (The Population Council, International Programs, 1 Dag Hammarskjold Plaza, NY, NY 10017).
10. SEATS II Quality of Care in Family Planning and Reproductive Health, Appendix A: Suggested Tools and Resource Guide for Quality of Care. JSI. July, 1996. (JSI, SEATS Project, 1616 N. Fort Myer Dr., Suite 1100, Arlington, VA, 22209).
11. Designing a Family Planning User Fee System: A Handbook for Managers. L. Day, John Snow, Inc., 1993. (JSI, SEATS Project, 1616 N. Fort Myer Dr., Suite 1100, Arlington, VA 22209).
12. Assessing Your Organizational Assets. The Enterprise Program. JSI, 1986. (JSI, SEATS Project, 1616 N. Fort Myer Dr., Suite 1100, Arlington, VA 22209).
13. Beyond the Clinic Walls: Case Studies in Community Based Distribution. J.A. Wolff, et al, Management Sciences for Health, 1990. (Kumarian Press, Inc., 630 Oakwood Avenue, Suite 119, West Hartford, CT. 06110-1529).
14. Project Planning Manual for NGOs. Jenny A. Huddart, Initiatives, Inc. UNDP HIV/AIDS Regional Project for Asia and the Pacific. New Delhi, India, 1993. (Initiatives, Inc., 276 Newbury St., Boston, MA 02116).

Internet Reference

Among many potentially useful websites to explore, for General Contraceptive Information, and a guide to additional sources of specific information, see: <http://www.conrad.org/general.htm>

The goal of the STI/HIV/AIDS intervention is to prevent the spread of HIV through education and motivation for behavior change. Important strategies include developing and teaching locally appropriate strategies for negotiating risk reduction with sexual partners, increasing skills of program beneficiaries to use condoms and/or negotiate other forms of "safer sex," and establishing sustainable systems to distribute condoms at community level. It may also be appropriate to carry out, or to support, referral for HIV/Sexually Transmitted Infections (STIs), informed voluntary counselling and HIV testing, and/or other prevention, care, and support activities.

This intervention is most appropriate for PVO child survival programs in areas with a high prevalence of STIs, and/or a rapidly increasing prevalence of HIV infection. HIV/AIDS activities are more likely to be successful if program staff include those with prior experience with this work. These activities also are best carried out in sites where the PVO has earned the trust and confidence of the community in a well established health or child survival program.

Proposing a relatively small effort (for example, less than 15-20% of a child survival program budget) for a complex new activity such as HIV/AIDS, usually is only justified if it is clearly linked with other related efforts, has strong community and political support, and does not overtax staff and resources committed to other proposed program interventions.

Targeting increases in knowledge usually is only justifiable if local studies have shown low levels of understanding of the basic facts about HIV/AIDS. More often, knowledge of the facts is adequate, but motivation, skills, and resources to change high risk behavior and situations are needed.

It is critical that appropriate referral sources be available in response to the demand created by educational efforts. All proposed activities should be culturally acceptable and consistent with the host country HIV/AIDS policies and strategies.

The intervention should have well-defined audiences, include participation of these audiences in planning, implementing, and evaluating HIV/AIDS activities, and collaborate with local counterparts. Because of the importance of STIs in the transmission of HIV, PVOs are encouraged to include activities to interrupt the transmission of STIs. The syndromic approach, a relatively quick and effective way to diagnose and treat STIs in men, should be considered. When combined with better drug supply, and with the "five C's of quality care" (confidentiality, condom supply, counselling, compliance with treatment, and contact tracing), the syndromic approach can make STI services more widely available through primary care clinics.

Highly Recommended Reference Materials 1. Mercer MA, Munz M, Editors. Including HIV/AIDS Prevention Activities in PVO Child Survival Projects. Task Force Report. PVO Child Survival Support Program, The Johns Hopkins University School of Hygiene and Public Health, Department of International Health, Baltimore, Maryland. June 1995. This publication includes additional references useful for Program Managers.

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Other Recommended Reference Materials

3. Lamphey P, Tarantola D, Netter T, editors. Handbook for AIDS Prevention in Africa. Family Health International, 1990. Available from: Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709.

4. HIV/AIDS Strategic Action Plan for Asia. U.S. Agency for International Development, Bureau for Asia, Washington, DC, June 1993.

5. AIDSCAP handbooks: (a) How to create an effective communications project, (b) How to conduct effective pretests, and (c) Assessment and monitoring of BCC interventions. Available from AIDSCAP, 2101 Wilson Blvd., Suite 700, Arlington VA, 22201. Phone: (703) 516-9779, Fax: 516-9781.

Internet References

UNAIDS: <http://www.unaids.org/> (This site has links to many other HIV/AIDS websites.)

AEGIS: AIDS Education Global Information System: <http://www.aegis.com/> Billed as the largest AIDS database in the world. Has searchable databases, links to other resources, as well as current news about HIV/AIDS.

BHR/PVC currently defines Integrated Management of Childhood Illness (IMCI) in terms of the IMCI strategy, activities, and training materials of national Ministries of Health, and supports PVO involvement in IMCI only when part of an official national effort to adapt and introduce IMCI.

According to WHO, the IMCI "strategy combines improved management of childhood illness with aspects of nutrition, immunization, and several other influences on child health, including maternal health. Using a set of interventions for integrated treatment and prevention of major childhood illness, the IMCI strategy aims to reduce death and the frequency and severity of illness and disability, and to contribute to improved growth and development. This set of interventions aims to improve practices in both health facilities and in the home.

"The core intervention is integrated case management of the five most important causes of childhood deaths (acute respiratory infections ARI, diarrhoea, measles, malaria, and malnutrition) and of common associated conditions. In individual countries, the combination of interventions that makes up IMCI may be modified to include other important conditions for which effective treatment and/or preventive practices have been identified. The main interventions of the global strategy may evolve, as new findings from analysis of the global burden of childhood disease and from child health research become available.

"Implementation of the IMCI strategy in countries involves the following three components:

- Improvements in the case management skills of health staff through the provision of locally adapted guidelines on integrated management of childhood illness and activities to promote their use.
- Improvements in the health system required for effective management of childhood illness.
- Improvements in family and community practices." ¹⁰

According to WHO, "in health facilities, the IMCI strategy promotes the accurate identification of childhood illness in outpatient settings, ensures appropriate combined treatment of

¹⁰ IMCI information: Integrated Management of Childhood Illness (IMCI). Management of childhood illness in developing countries: Rationale for an integrated strategy. Division of Child Health and Development, World Health Organization, September 1997.

all major illnesses, strengthens the counselling of caretakers and the provision of preventive services, and speeds up the referral of severely ill children. The strategy also aims to improve the quality of care of sick children at the referral level. In the home setting, it promotes appropriate care seeking behaviors, improved nutrition and preventive care, and the correct implementation of prescribed care."

Wall charts and modules for training health facility clinicians in integrated case management are available for use under carefully monitored conditions, but require adaptation for use in all countries, an extensive effort which may take six months or more. Not all countries eligible for PVO Child Survival grants have accepted the approach. As of September 1997, the following countries were preparing for, or had already begun, national IMCI training activities:

- | | | |
|----------------|---------------|---------------|
| • Benin, | • Haiti, | • The |
| • Bolivia, | • India, | Philippines, |
| • Botswana, | • Indonesia, | • Senegal, |
| • Brazil, | • Madagascar, | • South |
| • The | • Mali, | Africa, |
| Dominican | • Morocco, | • Tanzania, |
| Republic | • Nepal, | • Togo, |
| • Ecuador, | • Niger, | • Uganda, |
| • El Salvador, | • Nigeria, | • Vietnam, |
| • Eritrea, | • Peru, | • Zambia, and |
| • Ethiopia, | | • Zimbabwe. |

In order to insure consistent and up-to-date approaches in managing and referring ill children, PVOs working with health facilities in these countries are encouraged to keep in touch with the MOH, WHO, UNICEF, and/or BASICS concerning IMCI. All PVOs involved in managing sick children with malnutrition, diarrhea, pneumonia, malaria, or measles, are also encouraged to review the IMCI materials for up-to-date information concerning these interventions. In areas where IMCI has not yet been introduced, health professionals may still be trained to effectively manage sick children using the intervention-specific protocols and training materials recommended by the MOH.

The current training materials and algorithm for assessing and treating children are designed for literate first-level health facility clinicians, and are not appropriate for marginally literate health workers. Materials for a complementary IMCI course, based on the same algorithm, but designed for less literate health facility clinicians, are being developed by BASICS. PAHO is developing appropriately simplified IMCI algorithms and training materials for community health workers.

Until these become available, programs that train CHWs should use intervention-specific algorithms and training materials designed specifically for community health workers. For example, the WHO ARI materials for CHWs (cited in the PCM section of this document), that address the overlap in the clinical presentation and treatment of pneumonia and malaria, are appropriate, more broadly integrated materials for CHWs.

The activities required to strengthen the health system for IMCI are those that will improve local planning, supervision, drug management, organization of work at health facilities, monitoring/evaluation, and community-focused activities. These are the same activities required for delivery of any child survival intervention by the formal health system. Although these system strengthening interventions must be consistent with national policies (e.g. policies on drug selection), they can be carried out irrespective of the stage a country has reached in preparing for or implementing IMCI case management training.

The activities required to improve family and community practices as part of IMCI are the same community-based and IEC interventions discussed in other sections of this document. However, the strategy and definition of IMCI at the community level is still evolving. Thus, until consensus can be reached and materials are available for implementation of IMCI at the community level, BHR/PVC suggests that PVO programs integrate a carefully selected package of complementary child survival interventions that address the major child survival problems of the community, and continue to describe planned child survival activities at the community level in terms of the specific interventions and activities discussed in other sections of this document.

Internet Reference

More information on IMCI may be found on the website of the WHO Division of Child Health and Development (<http://www.who.ch/chd>).

United States Agency for International Development
Bureau for Humanitarian Response

DRAFT
(August 28, 1998)

Guide for
Detailed Implementation Plans
For PVO Child Survival Programs

Office of Private and Voluntary Cooperation
PVO Child Survival Grants Program

DIP Due Date: March 31, 1999

BHR/PVC is grateful for the many contributions to this document from public health specialists consulted through the Johns Hopkins University PVO Child Survival Support Program, the American College of Nurse Midwives, the BASICS, SEATS, LINKAGES, and OMNI projects, and through other offices of USAID.

The enclosed documents and the DIP review process are designed to help PVOs plan and implement high quality child survival programs. This "Guide for Detailed Implementation Plans" complements the attached "Technical Reference Materials," which briefly describe the essential elements of the child survival interventions supported through the PVO Child Survival Grants Program.

The DIP is the PVO's workplan for implementing the child survival program and is the basis for future evaluation of the program's success. PVOs may make changes in the selection of interventions and implementation strategies in their DIP from what was proposed in their grant application. The PVO's CS program is then expected to be implemented according to its approved DIP. Any further changes in the program description, such as interventions, sites, or beneficiaries, must be approved by the PVO's headquarters, USAID/BHR/PVC, and the Agreements Officer.

Generally, the field office of the PVO and the local partners develop the DIP, based on collaborative work at the field level. It is then reviewed and approved by the PVO's headquarters, before being submitted to USAID. One element of "substantial involvement" in your Cooperative Agreement with USAID is approval of the project workplan. USAID will schedule meetings with a representative of your PVO, BHR/PVC staff, and other technical experts, to review the strengths and weaknesses of the DIP and to make recommendations for improvements to insure a successful program.

BHR/PVC welcomes suggestions for improving these documents. Please submit your suggestions for improvement in writing to Katherine Jones (internet e-mail: kjones@usaid.gov), or contribute written or oral suggestions during the DIP review meetings.

Submission Instructions

Please include the following on your DIP cover page: Name of PVO, program location (country/district), cooperative agreement number, program beginning and end dates, date of DIP submission, and (on the cover or on the next page) the names and positions of all those involved in writing and editing the DIP.

Since different sections of the document may be reviewed by different reviewers, to facilitate the review, we suggest that you use the same order and numbering system used in this guide. You may provide tables and additional materials in the main body or in the annexes of your DIP.

Some redundancy in this guide is inevitable, given the interrelated nature of the interventions. You may reference other sections of the DIP instead of repeating the same information in several different sections.

If a topic in this guide does not apply to your program, please indicate this in your DIP. If your program has not yet obtained sufficient information to fully describe an element, then please indicate when and how you plan to obtain this information.

The DIP for each CS-XIV field program is due at BHR/PVC on or before March 31, 1999. We suggest that programs allow sufficient time for field work, writing, and editing. Failure to submit a DIP on time to BHR/PVC could result in a material failure, as described in 22 CFR 226.61.

Please send BHR/PVC the original and two (2) copies of each field program DIP. The original DIP should be one-sided and unbound. The two copies of the DIP should be double-sided, and bound separately. To facilitate review and preparation of approval documents, please also submit to BHR/PVC one diskette of the DIP in WordPerfect 5.1 or 5.2. DIP annexes which are available to you only in hard copy and not on disk may be excluded from the version submitted on diskette. In addition, please send one copy of the DIP to the concerned USAID Mission.

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Annexes

- I. Report of baseline assessments.
- II. Agreements with other organizations.
- III. Resumes/CVs of key PVO staff (if changed from application).
- IV. - Other annexes (as desired).

A. Field Program Summary (Please complete the tables below.)

PVO/Country: _____ Program duration
(dates): _____

1. ESTIMATED PROGRAM EFFORT AND USAID FUNDING BY INTERVENTION

Intervention	% of Total Effort (a)	AID Funds in \$ (b)
Immunization	%	\$
Nutrition and Micronutrients	%	\$
Breastfeeding Promotion	%	\$
Control of Diarrheal Disease	%	\$
Pneumonia Case Management	%	\$
Control of Malaria	%	\$
Maternal and Newborn Care	%	\$
Child Spacing	%	\$
STI/HIV/AIDS Prevention	%	\$
Others (specify)	%	\$
Total	100%	\$

- (a) Estimate the percentage of total effort (from USAID and PVO match funding) the program will devote to each intervention to be implemented.
- (b) Estimate in US dollars (not in percent) the amount of USAID funding (excluding PVO match funds) the program will devote to each intervention.

2. Program Site Population: Children and Women (c)

Population Age Group	Number in Age Group
Infants (0-11 months)	
12-23 Month Old Children	
24-59 Month Old Children	

Total 0-59 Month Olds	
Women (15-49 years) (d)	

(c) Estimate the number of people in the age group that the program expects to serve. Do not add annual births. If the program is phasing-in geographic areas over time, then estimate the population to be covered by the end of this funding cycle (after all areas have been phased-in).

(d) Estimate the number of women if data is available.

◆ Estimated annual number of live births in the site:

◆ Sources of the population estimates above:

B. Response to Proposal Review Comments

- ◆ Explain how the DIP responds to each concern expressed in the technical review of the original application. You may reference the section of the DIP that addresses the concern.

C. Response to Final Evaluation Recommendations (if applicable)

- ◆ If this is a DIP for a follow-on program and a final evaluation has been completed, how is the program addressing each of the recommendations made in the final evaluation? You may reference the section of the DIP that addresses the recommendation.

D. Program Goals and Objectives

- ◆ Using any format you prefer (tables, graphics, narrative), please briefly state program goals, program objectives (you may express these as results), measurement methods for objectives/results, major inputs, and major outputs and measurement methods.

E. Program Location

- ◆ Include a readable map which shows the location of the program impact area(s) relative to other regions of the country, and the program area itself. Label towns and give a scale. If possible, indicate existing hospitals, health centers, clinics, and/or health posts.
- ◆ Briefly describe the location of the program, and identify the groups targeted for program activities. Briefly describe the socio-economic characteristics of the population, such as economy, religion, ethnic groups, literacy, and status of women. Describe the nature and location of family members' work and identify which family members commonly take care of infants and children. Identify any groups in the program site that you consider at high risk of death, disadvantaged, or under-served. Identify potential geographic, economic, political, educational, and cultural constraints to child survival activities which may be unique to this location.
- ◆ Briefly describe the levels and major causes of under-five mortality in the country, and (if available) in the program area, and (if maternal mortality is to be addressed by the program) estimated levels and causes of maternal mortality. Include the sources of all mortality data.

- ◆ Briefly describe all the existing public and private, formal and traditional health and child survival related programs, facilities, and activities in the program area.

F. Baseline Assessments

The baseline assessments should focus the program on the site's priority health needs, help the program design effective strategies to deliver child survival services and support existing health activities, and set measurable objectives. PVOs are encouraged to conduct assessments of the quality, coverage, and needs of existing health facility/worker services, and to use qualitative/ethnographic methods to collect baseline information on local knowledge and practices related to the program. PVOs may use relevant sections of the KPC Survey¹ to collect quantitative survey information on immunization coverage and maternal practices, and set measurable objectives.

- ◆ Briefly discuss the types of baseline assessments conducted by the project.
- ◆ Identify the in-country organizations, community leaders, and community groups that worked with you on the baseline assessments and design of the program.
- ◆ Summarize the findings of baseline assessments in this section, and/or in other sections of the DIP, as you see fit. For quantitative survey findings, indicators, or objectives, please include numerators, denominators, and percentages. If you changed your program objectives based on the results of the baseline assessments, please describe how you made your decision.
- ◆ Please include a full report of the baseline assessments, including a description of methods and copies of questionnaires and other tools, in an annex of the DIP.

G. Program Design

- ◆ Describe your overall program design (in greater detail than in the application). Discuss the relationship this program will have with the health facilities, and with other health related activities, in the project area. Describe the process by which eligible women, children, and newborns will enter and participate in the program. Address how program interventions will be implemented in an integrated way.

¹ The KPC Survey is the standard Knowledge, Practice, and Coverage Survey developed by the Johns Hopkins University PVO Child Survival Support Program under contract with USAID/BHR/PVC.

- ◆ Discuss the relationship between the choice of interventions and strategies, and: (1) the causes of death, (2) the strengths and weaknesses of existing health services in the area, (3) the preferences of community members, and (4) in relation to the expertise of the staff of your program and its local partners.
- ◆ If child survival interventions proposed in the PVO's original grant proposal have been added or removed, then describe the rationale for the change in interventions between the application and DIP.
- ◆ Describe any innovations, new methods, strategies, or materials you plan to implement or develop, which may be used or applicable on a wider scale in the future. Briefly describe any discussions you have had with the MOH concerning any planned operations research, or concerning any innovations which could be adopted on a wider scale in the future.

H. Workplan

- ◆ Complete a workplan for the life of the program, in detail for the first two years of the program. Include a calendar of major activities, annual benchmarks toward results/achievements, and responsibilities among field, headquarters, and partners.

I. Partnership

- ◆ **Public Sector:** Describe the PVOs' partnership with the government organizations responsible for implementing primary health care activities in the project area. Describe their current capacity, including financial, human, and material resources, and how the PVO plans to increase the managerial and technical skills of the staff. Attach in an annex a copy of the jointly signed agreement which clearly shows the roles, responsibilities, and capacity strengthening plans with these organizations. Identify any other organizations which are already working or will be working in primary health care at the site with the public sector.
- ◆ **NGOs:** Describe the PVOs partnership with the NGO(s) (including local affiliates of the U.S. PVO) involved in implementing health-related activities in the project area. Describe their current capacity, including financial, human, and material resources, and how the PVO plans to increase the managerial and technical skills of their

staff. For each partnership, attach in an annex a copy of the jointly signed agreement which clearly identifies the roles, responsibilities, and capacity strengthening plans. Identify any other organizations which are already working or will be working at the site with the NGOs.

- ◆ Community-based organization(s): Describe the PVOs partnership with the community-based organization(s) involved in implementing health-related activities in the project area. Describe the community-based organizations' current capacity, including financial, human, and material resources, and how the PVO plans to increase the managerial and technical skills of these organizations. Identify any other groups which are already working or will be working at the site with these organizations.

J. Sustainability

- ◆ Define what 'sustainability' means from the perspective of the PVO, the program partners, and the beneficiaries.
- ◆ Describe in detail your sustainability plan for the program, including goals, objectives, and activities. Include in your discussion:
 - what the program will leave in place at the end of the grant;
 - how the financial and non-financial support required to continue program benefits will be sustained after the end of the grant; and
 - the process used to develop the sustainability plan.

K. Human Resources

- ◆ Update the organizational chart in the application to define the relationships between the types of organizations, committees, and persons related to the project.
- ◆ For each kind of field staff with whom the project will work (including MOH and NGO health workers, their supervisors, and all other personnel involved in the delivery of program-related child survival services):
 - (1) identify the type of health worker (e.g., nurse, community health worker, traditional birth attendant),
 - (2) identify their current organizational affiliation (or note that the staff are to be recruited in the future),
 - (3) identify whether they are paid or volunteers,
 - (4) estimate the number of this type of worker to be involved in the program,

- (5) list their main duties related to the supervision and provision of child survival services, and
 - (6) estimate their time devoted to child survival activities.
- ◆ What is the ratio of health workers to the number of families or beneficiaries? How intensive, in terms of the types and numbers of health workers used, is the program compared to the MOH?
 - ◆ For each type of health worker providing child survival services, estimate the number of hours of training to be provided for each intervention, for both initial and refresher training. How will the program ensure that trainees have gained adequate knowledge and skills? How will newly trained workers receive continuing supervised practice?
 - ◆ Estimate the percentage of the workers and/or volunteers that will be replaced every year, and discuss the reasons for worker turnover, and what the program will do to minimize the rate of turnover.
 - ◆ Describe the committees and community groups with which the program will work, their role in the child survival program, and the number of each type of group. Describe how the program will work with the community groups and identify which staff will work with the groups.

- ◆ Briefly explain the rationale for working with these types and numbers of health facilities, workers, and committees. Describe how these facilities, groups, and health workers will relate to each other, and the linkages between these entities and the communities being served by the child survival program.
- ◆ Include in an annex the resumes/CVs of key PVO headquarters and in-country program staff, if these have changed from the application. Name the individual(s) from the U.S. PVO responsible for technical backstopping of this program. How many site visits will be made each year, for how long, and for what purpose?

L. Health Information System

- ◆ Describe the data collection system for this program. How will program progress be monitored? Specify which data variables you will collect to monitor program activities and progress. Describe how this data will be collected, from whom it will be collected, how often it will be collected, and by whom.
- ◆ Describe plans for data analysis, use, and dissemination to program staff, the community, MOH authorities, and the PVO home office.
- ◆ Describe the methods that will be used to monitor and improve the performance of health workers and the quality and coverage of intervention activities (including those carried out in cooperation with other organizations). Discuss the project's plans for on-going assessments of essential knowledge, skills, practices, and supplies/drugs/equipment of health workers and facilities associated with the project, and use of findings to improve the quality of services. Describe the tools to be used by the project to promote quality of service (such as: guidelines, training curricula and manuals, protocols, algorithms, performance standards, and supervisory checklists, etc), and briefly describe how these tools will be used to assess and improve performance.

M. Budget (if changed)

- ◆ If there has been changes in the program's site, selection of interventions, number of beneficiaries, international training costs, international travel, indirect cost elements, or the procurement plan, include a revised budget with your DIP. The budget is to be submitted on revised

forms 424 and 424A. Grantees should be prepared to justify costs by providing the needed information to the Project and Agreement Officers.

N. Reference Materials

- ◆ Identify the principal technical reference materials used for the content of health worker training for each intervention. For each reference, identify the organization(s) which published the reference, and the year of publication.

O. Detailed Plans by Intervention

- ◆ Include a separate section for each USAID-funded child survival intervention that the program will implement or support. Please address the issues in the intervention-specific sections of this guide, below.
- ◆ Please consider the technical support and training your PVO might require to successfully implement each intervention, and describe the support required in the section "Technical Assistance Plan," below.

IMMUNIZATION

Programs implementing an immunization intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Incidence and Outbreaks

Provide the most recent vaccine preventable diseases surveillance data available for the program area, and discuss the likely completeness of reporting. Describe any outbreaks of vaccine preventable diseases that occurred in or near to the program area within the last two years.

2. Baseline Coverage Estimates

Give the most up-to-date coverage estimates in your service area for DPT1, OPV3, and measles, in children age 12-23 months, and identify the source of these estimates. Estimate the current dropout rate for DPT immunizations $[(DPT1 - DPT3) \div DPT1]$. Estimate the percent of children 12-23 months who are completely immunized. Describe the tetanus toxoid (TT) immunization status of women of childbearing age or the percentage of births protected by TT. Compare your data with the most recent data available for the district, or with national coverage levels.

3. MOH Policies and Current Services in the Area

Describe the MOH immunization strategy. Include the MOH immunization schedule for your country or program area. Include details on any MOH immunization policies that differ from WHO/UNICEF guidelines, and describe why they differ.

Describe the current immunization services in the program area. Are immunizations given from fixed or mobile facilities? Can program beneficiaries obtain immunizations all year, or only during campaigns? What are the means for making up missed immunizations? Discuss the overall quality of existing immunization services, and describe existing barriers to achieving full immunization coverage in the program area.

4. Program Approach

Describe your planned immunization component for children and for women of childbearing age; include PVO and MOH roles in education, community mobilization, vaccine administration, and in monitoring and improving the quality of immunization services.

Calculate the number of visits required to reach full coverage for children by 12 months of age. Which, and how many, women will the program target for TT. How does the program plan to reach "high risk" populations?

IMMUNIZATION

How will staff protect themselves from exposure to blood-borne infections? How will the PVO ensure single use of needles and syringes? What is the disposal plan for needles and syringes?

5. Knowledge, Practice. and IEC

Describe current knowledge and practices of mothers and families regarding immunization.

Describe your plans for information, education, and communication for the immunization intervention. Define your behavior change objectives for immunization and the groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on caretaker knowledge and practices? What are the key messages the program plans to convey to the population to promote immunization?

6. Individual Documentation

Attach the immunization card that the program will use. How will immunizations be recorded during mass campaigns. On what document will womens' TT vaccination be recorded? Who keeps the cards? How will the program minimize card loss? What will be done if a card is lost? How reliable is the card supply?

7. Drop-outs and Missed Opportunities

Describe the major causes of, and strategies for reducing, the number of dropouts and missed opportunities for childhood immunization in your program area.

Describe the major causes of, and strategies for reducing, the number of dropouts and missed opportunities for tetanus toxoid immunization of women in your program area, and the strategy for increasing demand for tetanus toxoid immunizations.

8. Vaccine Supply and Cold Chain Support

From what source will the program obtain the vaccines? How do they monitor vaccine quality? How will the supply of vaccines be ensured?

Identify existing weak links in the cold chain and the source of this assessment. What does the program intend to do in cold chain maintenance and monitoring? How will malfunctions in cold chain equipment be addressed? Identify (from your procurement plan) equipment you have purchased (or will purchase) to monitor and maintain the cold chain.

9. Vitamin A (optional)

Is vitamin A deficiency present in the program area? If so, how does the PVO plan to incorporate vitamin A supplementation into the program?

10. Involvement in Polio Eradication Efforts (optional)

IMMUNIZATION

Describe any plans for involvement of the program in polio eradication efforts, or in national immunization days.

11. Surveillance (optional)

If you plan to have EPI disease surveillance activities, identify the vaccine preventable diseases that will be under surveillance. For each of these diseases, briefly discuss the case definition used. How will surveillance be carried out and by whom? Describe the process for identifying, reporting, and following-up suspected cases. What are the respective roles of the PVO and MOH in surveillance and in responding to disease outbreaks?

PVOs implementing a nutrition and micronutrients intervention are NOT expected to include all components (infant/child nutrition, growth monitoring, maternal nutrition, micronutrients, supplemental foods, and home gardens) in their programs. Thus, PVOs should address all of the issues in only those sections below which are included in the program, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

I. Infant and Child Nutrition

1. Nutrition Status

Provide the most up-to-date estimates, and source and year of data, for the percentage of malnourished children in the region or service area by age (0-5, 6-11, 12-23, and 24-35 months). Indicate whether estimates are based on weight-for-height, weight-for-age, or height-for-age measurements/indices, and give the method/expression used (Z-scores, percentage of median, or percentiles) to compare the measurement to reference standards.

Discuss issues of seasonality, gender, ethnic, or demographic characteristics (i.e., ethnic groups, rural or urban residence, region) related to child nutritional status. Describe the food security situation, availability, and access, and likely causes of childhood malnutrition in the program area, including: food crop production, markets, income sources, family food expenditures, etc. Include any additional appropriate information which would contribute to understanding the existing nutrition situation.

2. Current Beliefs and Practices

Describe the usual infant and child feeding practices in the area, including breastfeeding, complementary foods, feeding frequency, how children are fed and by whom, by age of child (<6 months, 6-11 months, 12-17 months, 18-23 months, and 24+ months).

Describe reasons for current practices, including cultural beliefs of mothers and other family members that apply to infant feeding practices and to the distribution of food within families. Describe possible constraints and motivations for changing behavior. What individuals, services, and media may influence child feeding? Whom do mothers trust for advice on child feeding, and who makes decisions in the household on child feeding and the distribution of food within families? Include discussion of health care providers (government, traditional or non-formal practitioners) knowledge, attitudes, and skills related to counseling on child feeding and nutrition. Include information about feeding children during and following illness.

3. MOH Policy and Activities in Area

Describe national government policies or programs which affect the nutritional status of infants and children at the community level, including supplemental feeding programs. Describe the experiences and effectiveness of public and private programs in improving child nutrition and feeding behaviors. Describe the fortified foods available in the area, and whether children consume them.

4. Program Approach

Discuss your strategy for improving children's nutritional status in the program area. Describe how the program will coordinate nutrition interventions with existing nutrition activities in the area and with other MCH activities (such as immunization, maternal care, or family planning). Discuss how strategies may differ for different segments of the target population.

What strategies will the program use to increase caloric intake and improve dietary diversification in vulnerable children? What nutrition messages will the program deliver? How will the program develop community support systems to reinforce behavior change?

Discuss how strategies may differ for different segments of the target population. Discuss how the program will monitor and improve the quality of intervention activities.

II. Growth Monitoring

1. Status

What is the purpose of growth monitoring in your program? What are the beliefs and practices of mothers and families about infant and child growth, and attitudes toward weighing? Discuss beliefs and practices of health workers that may affect growth monitoring project development. Describe strategies for promoting effective individual and community participation, and strategies for sustaining effective GM project activity. If the MOH provides growth monitoring/promotion services, include national standards. Describe current growth monitoring activities in the program area.

2. Approach

How will your strategy address the major issues of supervision and counselling? How frequently are young children weighed? What is the level of compliance in attendance and counselling? How will your strategy overcome any constraints?

Describe how your program is involved in weighing children, interpreting growth patterns, and providing nutrition counseling. Discuss how the program will train and supervise health workers, including quality assurance in service delivery. If the MOH weighs the children, what is the PVO's role and how is it coordinated with the MOH?

On which children in the program site will the program focus? How does the program plan to reach these children? Describe your criteria for determining growth faltering. Once a child is identified as growth faltering, what steps will the program take to improve that child's growth and prevent the child from faltering in the future? How will data collected from

growth monitoring be used to monitor the effectiveness of the program's nutrition intervention? What mechanisms will be developed to provide feedback to staff and the community?

Attach a copy of the growth card the program will use, and describe what the program will do in the case of a lost card. Who keeps the card? Who provides these cards? How reliable is this supply? If the supply is unreliable, how will the project address this?

III. Maternal Nutrition

1. Maternal/Newborn Nutrition Status

If data are available, what is the baseline height/weight distribution for women in the program area? What is the distribution of weight gain during pregnancy, and of birth weights, in the area? Does the program have any plans to collect additional data, such as data on anemia or night blindness prevalence?

2. Current Beliefs and Practices

What are the local beliefs about food consumption and weight gain during pregnancy and lactation? From whom do mothers seek advice during pregnancy and lactation? Estimate the percent of women who consume iron, folic acid, vitamin A, vitamin C-rich foods, and iodized salt during pregnancy. What are the local beliefs with regard to food consumption and weight gain during pregnancy and lactation? What beliefs do mothers have about their ability to breastfeed successfully? What precautions or changes in work habits do mothers make during pregnancy and lactation? If the program works with women employed in the formal sector, what are the maternity leave policies? Describe the most likely causes of maternal nutritional problems in the program area.

3. MOH Policy and Activities in Area

What are the national government's specific policies and programs for maternal nutritional improvement?

Describe current nutrition or food policies, programs, and activities, including fortification; supplementation (iron/folic acid); and supplemental feeding programs, which effect the nutritional status of pregnant and lactating women in the program area.

4. Program Approach

Explain how the program will address the issues identified above. Describe your strategy for identifying and enrolling pregnant and lactating women in nutrition programs. How will your program relate to existing government or private programs? How will the program reach high risk groups? What messages will the program give to pregnant and/or lactating women? Discuss any qualitative assessments that your program has done, or will do, to develop appropriate nutritional messages and materials. What educational methods will the program use with mothers and influential family and community members? Who will the program train to provide these messages? How will the program monitor the effectiveness of these messages in behavior change?

IV. Micronutrients

1. Status

Include estimates of the prevalence of night blindness, anemia, and goiter, where available. What are the national standards for micronutrient supplements for children and pregnant and lactating women? What micronutrient supplements are included in the essential drug supplies?

2. Approach

Describe who will receive micronutrient supplements, when and under what conditions these will be given, and the specific purpose of the supplementation. Give details on supplement distribution, including the following: dose by age group (for both prevention, and if applicable, treatment); the source and reliability of the supplement supplies; and whether the program or MOH will distribute supplements when needed or through mass campaigns. If the program area has a high prevalence of anemia and hookworm, how will the program address this?

Describe the program strategy for dietary approaches to micronutrient deficiencies. Address the same counselling and quality control issues raised in growth monitoring, as they pertain to micronutrients.

V. Supplementary Foods

If the PVO will provide supplementary foods (other than micronutrients) as a complement to the Child Survival activities, identify the food source, and describe the activities planned. Who will be eligible for supplemental feeding? How often will the program give supplementary foods? Who will monitor the supplemental feeding, and what will be monitored? For how long will supplementation activities continue? Will food supplements be phased-out?

VI. Home Gardens

If the PVO will promote home gardens as a complement to the Child Survival program nutrition activities, describe the activities, the purpose of these activities, the foods that will be grown, the educational techniques the program will use, and PVO inputs for gardening supplies and agricultural expertise. Describe the program's plans to monitor and evaluate this activity, including establishing baseline conditions.

Programs implementing a breastfeeding promotion intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program intends to integrate breastfeeding promotion into other interventions, then please describe the breastfeeding component in this section. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Knowledge & Practices

Describe current breastfeeding practices in the impact area, including time of initiation, prelacteals, colostrum, and duration of exclusive breastfeeding. Discuss reasons for failure to initiate breastfeeding. What do mothers who work outside of the home typically do?

When and what supplementary liquids/foods are typically introduced? What percentage of mothers are currently bottle feeding their infants, either alone, or as an adjunct to breastfeeding?

What do mothers know about the benefits of breastfeeding for themselves, the child, and for birth spacing? What are the current attitudes and beliefs of other family members, community leaders, and of staff associated with the program, towards breastfeeding?

Discuss constraints, both cultural and economic, to increasing exclusive breastfeeding.

2. MOH Protocols & Related Activities in the Area

What are the MOH policies and programs regarding breastfeeding promotion, including national plans and policies on infant formula? If there is a national program, how will this affect the project approach?

Describe any current breastfeeding promotion activities or organizations in the program area, and programs (commercial, public, or private) with policies that discourage breastfeeding or encourage breast milk substitutes. What are the hospital practices in the project area for breastfeeding and infant formula? Discuss health worker training in breastfeeding. Does your PVO have a policy regarding the distribution of infant formula in its programs? Do child spacing programs in the area include LAM as a method?

3. Approach

Describe your approach to breastfeeding. What are the plans to overcome the constraints? If other breastfeeding promotion activities exist in the program area, how are activities to be coordinated?

BREASTFEEDING PROMOTION

If many mothers of young infants work outside of the home, what strategies will the program use? Describe the role of other family members, significant others, or community members in the strategy.

If the program will promote LAM, how will it be integrated into other modern birth spacing activities?

4. IEC and Counselling

Describe your plans for information, education, and communication for breastfeeding. Define your behavior change objectives and groups to be targeted.

What practices will your program promote, and how? What key messages will the program convey about breastfeeding?

Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on caretaker knowledge and practices?

If counselling of mothers is included in the strategy, how will the program assure the quality of the counselling?

Programs implementing a diarrhea intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Incidence and Distribution

Give the most up-to-date estimates available for your program area or country for the average number of episodes of diarrhea, per year, per child. (Cite sources of data and year). Describe the seasonal variation in the prevalence of diarrheal diseases. Is dysentery in your program area resistant to some antibiotics? What information is available on the importance of dysentery and persistent diarrhea as causes of death in children?

2. MOH Protocols and Current Practices

Describe or attach the MOH protocol for standard case management of childhood diarrheal diseases. Include the MOH protocols for the management of dysentery and of persistent diarrhea in children. What home available fluids does the MOH recommend?

Describe current case management protocols or practices at the health facilities, and by health workers and drug retailers, in your program area. Describe current practices in your service area regarding the use of antibiotics (including metronidazole) and anti-diarrheal medications in the management of childhood diarrhea. Discuss the quality of the case management practices for dysentery and for persistent diarrhea.

3. Knowledge and Practice

Describe current knowledge and practices of mothers in the area regarding childhood diarrhea and the use of oral rehydration therapy. Include information on local words for diarrhea and its signs; causes; recognition of diarrhea, dysentery, persistent diarrhea, and dehydration; perceptions of severity; and home care, feeding, and breastfeeding practices. When do parents seek outside care for diarrhea, and whom do they consult?

4. Approach

Describe your CDD intervention. Describe or attach your protocol for home management of diarrheal diseases in infants and children, and for the management of more severe cases, including persistent diarrhea and dysentery.

If the program will train or supervise MOH staff (and/or private practitioners or retailers) in diarrhea case management,

then describe your plans for improving their case management practices.

5. ORS and Home Available Fluids

If the program is promoting the use of ORS packets, describe the ORS supply, logistics, distribution, availability, and the cost of ORS packets to mothers. How will the program monitor mothers', other caretakers', and health workers' skills in ORS preparation and use? Comment on the sustainability of ORS use in terms of cost recovery (if appropriate) and continued reliable supply.

If the program will promote the use of home available fluids, which widely available fluids will the program promote for the prevention of dehydration?

6. IEC

Describe your plans for information, education, and communication for management of diarrhea. Define your behavior change objectives and groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on caretaker knowledge and practices? What key messages will the program convey to the general population.

7. Prevention

Will the program educate caretakers about specific ways to prevent diarrhea? If so, what will be taught, and how will these educational activities be implemented and evaluated? If planned, include a brief description of water supply and sanitation activities.

Programs implementing a pneumonia intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

Quality Case Management

1. MOH case management policies, programs, and protocols

Which types of people (such as doctors, nurses, other paid health workers, volunteers, drug sellers, traditional healers, etc) are allowed to give antibiotics? What ARI (or IMCI) training programs and materials are available for these types of health workers?

Are the MOH protocols for ARI case management consistent with the WHO protocols? If not, what are the differences and the reasons for these differences?

2. Utilization and quality of current case management services in the program area

What types of health providers (such as MOH and to other facilities, private practitioners, CHWs, drug sellers, traditional healers, etc) currently treat children with pneumonia from your area? Estimate the number of each type of these providers currently treating children with pneumonia from your area. Estimate the relative utilization of each type of provider (percent of all childhood pneumonia-related visits to each type of provider). Which of these types of health providers will the child survival program work with to monitor and/or improve pneumonia case management services?

Estimate the percentage of each type of provider trained in standard case management of ARI (or in IMCI). Describe the supply of appropriate antibiotics available to these providers. How often are these providers supervised regarding their case management practices? Describe your findings regarding the pneumonia case management practices of current providers in the program area.

3. Program plans for involving workers who do not currently treat pneumonia

Will the program provide pneumonia-related training to any types of workers (such as community health workers) who do not currently treat childhood pneumonia? If so, briefly describe the responsibilities these workers will have regarding pneumonia.

Will these workers provide antibiotics for children with pneumonia? If so, is this approach approved by the MOH? How many of these additional workers will be trained to treat pneumonia?

Will they provide treatment from their homes, or from other places?

4. Program protocols for pneumonia and malaria case management

Describe or attach the program's protocols for the assessment, classification, and treatment of ARI, for each type of health provider associated with the program. (Include the signs that will lead to antibiotic treatment for infants under two months of age, for older infants, and for 12 to 59 month old children, and the signs which will result in referral to a higher level of care. Include cut-offs for fast breathing for each of the three age groups. List the antibiotics which each type of health worker will use for pneumonia.)

How will children be assessed for fast breathing? How will workers be trained to recognize chest indrawing?

Estimate the extent of falciparum malaria transmission in your program area. If applicable, describe how each type of health provider will address the overlap in the signs of malaria and pneumonia. Which drugs will be used for children with pneumonia who also have a fever, and for children without pneumonia who have a fever?

5. Counselling for antibiotic use, home care, and referral

Who will do counselling regarding antibiotic use and home care for children with pneumonia, and when will this counselling be done?

How will health workers determine whether caretakers of children requiring referral will promptly seek care at a referral facility? (In other words, how will workers decide whether referral is feasible for a family?) What will be done when referral is not feasible for a family?

6. Follow-up of children treated for pneumonia

Briefly describe or attach the program's protocol for follow-up of cases under treatment. How will you check whether caretakers are giving correct antibiotic doses, how will you define compliance failure, and what will be done in cases of compliance failure? How will you determine whether treatment was successful, define a treatment failure, and how will you manage cases of treatment failure?

7. Monitoring, improving, and sustaining the quality of case management

Describe in detail your plans for monitoring and improving the case management practices of each type of health provider associated with the program.

How will the program insure good continuing assessment, classification, and treatment practices? How will the program monitor and improve the quality of counselling? How will the program insure that providers have an adequate supply of antibiotics?

Will antibiotics be sold to parents or provided free of cost? How will antibiotic supplies be maintained following the end of USAID funding for the program?

Adequate Access

8. Current access

Estimate how much time and money it currently costs people from different areas of the program site to reach and use the services of their nearest providers of antibiotic treatment for pneumonia. (Include two-way travelling costs in time and money, waiting time at providers, and purchase of antibiotics and other fees.) Describe other important problems in your area related to access.

9. Definition of adequate access

Define the level of access (in terms of time and money) that the program considers "adequate" to allow caretakers in your area to promptly seek and use case management services.

10. Increasing Access

Estimate the percentage of the target population which currently has adequate access to treatment, or identify those areas/groups which do not have adequate access.

Describe what (if anything) the program will do to increase the level of access. Estimate the percentage of the target population which will have an adequate level of access to treatment following actions to increase access.

Essential Household Actions

11. Beliefs, practices, and vocabulary

Briefly discuss what you have found regarding the following issues, and/or your plans for investigating these issues in the near future:

Have you identified local words for fast breathing, difficult breathing, chest indrawing, and stopped feeding well in a young infant? Are these signs recognized by caretakers and considered serious?

Which pneumonia related signs lead caretakers to seek help outside of the household, how promptly is care sought, and from whom is help obtained?

Who makes decisions in the household about when and from whom to seek outside care?

What are the barriers in your area to prompt recognition, to prompt care seeking, and to compliance with treatment?

12. Communications for recognition and care seeking

Describe how information regarding local beliefs, practices, and vocabulary related to pneumonia recognition and care seeking will be used by the program. What are the objectives of your communications effort regarding pneumonia recognition and care seeking, and which groups will be targeted?

Which key messages will the program emphasize regarding recognition and care seeking for older infants/children, and for young infants?

How will this information be communicated, who will do this communication, when will it be done, and how often will it be done?

How will the program develop and test messages and materials, and monitor the quality of this communications effort and its impact on caretaker knowledge and practices?

PVOs implementing a malaria intervention may include all approaches to malaria control (malaria case management, antenatal prevention and treatment, and insecticide-treated mosquito nets) in their programs, but are NOT expected to do so. Thus, PVOs should address all issues in only those sections, of the three sections below, which are included in the program, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

I. Malaria Case Management

1. Impact of malaria in the community

What is the estimated level of malaria-related morbidity and mortality among children in the program area? How is this estimate made? What proportion of children are estimated to have chronic or persistent malaria with anemia? How is this measured? Describe the seasonality of malaria and malaria-related morbidity and mortality in the program area.

2. Case management policies & availability of appropriate drugs

What are the MOH policies and protocols for the management of malaria in health facilities and by community health workers? How is malaria being managed in the home? What are the MOH policies related to the overlapping presentation of malaria and pneumonia? What antimalarial drugs are available in health facilities, grocery stores, markets, and private pharmacies? Describe the pattern of drug resistance in the program area and whether alternate drugs are available and affordable.

3. Knowledge and practices related to recognition and treatment

How serious do mothers in the program area consider malaria in children and malaria in themselves? Who do they consult, or where do they take their children when they suspect malaria (to a health facility, a registered pharmacy, a community health worker, or a private clinician, drug seller, or traditional healer)?

What is the local terminology used for severe and non-severe malaria that may influence decisions in treatment seeking behavior? What are the local terms for conditions compatible with severe malaria, for which people may use traditional treatments in the home or from traditional healers, instead of modern antimalarial drugs? Describe traditional practices for the treatment of malaria episodes in children at home. Describe any other important local beliefs and practices concerning malaria. What are the most important social, economic, and/or cultural barriers to malaria management and prevention in your area? What

additional qualitative or ethnographic studies concerning the malaria intervention will be conducted by the program?

4. Improving case management by health providers and in the home

Describe the current case management practices of health workers and of shop keepers in your area, and your planned approach for improving malaria case management. How will the program collaborate with the MOH in implementing the malaria component? Describe the access to treatment for severe malaria at health facilities, and plans to insure referral of severe cases by health workers and shop keepers.

Attach the program's protocol for the case management of malaria at all levels (including how the overlap in the presentation of malaria and pneumonia will be addressed by all those who assess or treat children for malaria or fever).

Will the program teach caretakers how to treat malarial attacks with over-the-counter drugs or train storekeepers in malaria treatment? How will the program ensure that shops sell appropriate drugs, proper dosages, and full courses of treatment?

II. Antenatal Prevention and Treatment

1. Impact of malaria in pregnancy in your program area

Based on information from local hospitals, antenatal clinics, or from community surveys, what proportion of pregnant woman are infected with malaria, what proportion are anemic, and how common are complications of malaria in pregnancy?

2. Drug treatment or prophylaxis protocol

What is the pattern of drug resistance in your area? What drugs are available? Based on this information, what drug treatment or prophylaxis protocol will you use for malaria in pregnancy?

What is the current MOH policy on antenatal treatment and prophylaxis? If the program protocol is different from MOH policy, why is there a difference, and is your protocol acceptable to the MOH? Will the program contribute to changing MOH policy?

3. Plan for providing malaria treatment or prophylaxis

What proportion of pregnant women visit an antenatal clinic, and when do they visit? What efforts will be made to reach women pregnant for the first time? How will you provide malaria treatment and/or prophylaxis to pregnant women? How does this fit in with your overall plan for providing maternal and newborn care?

4. Acceptability and feasibility of the protocol

The following questions should be addressed for both mothers and health workers who will be providing antenatal services: Is malaria or anemia recognized as a complication of pregnancy, and are the proposed drugs acceptable? Why? How would you address their concerns if they are not acceptable? What other health communication activities will you carry out to promote acceptance of this protocol?

III. Insecticide-Treated Mosquito Nets

1. Demand and appropriate use

Does malaria transmission occur throughout the year, or only during certain months?

What is known about current use of untreated nets, including the proportion of houses with nets, who in the household uses nets, and seasonal patterns of net usage? What is known about acceptability of insecticide treatment and re-treatment of nets?

What plans do you have to ensure that the mosquito net program reaches children under five years of age?

2. Access and affordability

Are any nets currently available for sale in your area? What material are they made of? Are nets produced locally? Is there a system for distribution and sales of the nets within the country? If appropriate nets are not locally available and your organization plans to import them, what are the associated costs (taxes, fees etc.)?

Describe how the program will organize the purchase, distribution, and re-treatment of the mosquito nets. What insecticide, dosage, and frequency of re-treatment have you chosen? Has this insecticide been registered for public health use in your country?

How much will the program charge for nets and for re-treatment, and how will this financing be organized? If either nets or insecticide will be sold at subsidized prices, who will pay for these subsidies when the program ends?

What local institutions will be involved in implementing and sustaining the intervention, e.g. rural credit schemes, agricultural cooperatives, health facilities, local shop owners, district and village governments? Is this program being coordinated with other mosquito net programs being implemented in the country, e.g. with regard to choice and import of insecticide and nets, and communication and financing strategies, etc.?

Discuss likely constraints to the success of mosquito net activities and approaches to overcome these constraints.

IV. IEC

CONTROL OF MALARIA

Describe your plans for information, education, and communication for each approach to malaria control (malaria case management, antenatal prevention and treatment, and insecticide-treated mosquito nets) which your program is implementing. Define your behavior change objectives and groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on knowledge and practices? Briefly list the key messages the program plans to convey to the target population.

MATERNAL AND NEWBORN CARE

Programs implementing a maternal and newborn care intervention should address the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Baseline Information

What is the maternal mortality ratio (maternal deaths per 100,000 live births) in the program area/country? Cite sources.

2. MOH Policies, Current Public and Private Services

Briefly describe the national maternal health policies and program.

What information exists concerning maternal mortality, morbidity, and practices in the program area?

Describe the public and private services and facilities currently available in the program area, including prenatal, birth, and postpartum care. Which essential elements of care do these facilities provide? What equipment, drugs, and supplies are available for essential obstetric care?

Who provides services, and what formal and non-formal training do they have? What is the quality of these services, and how are they utilized by the community? Describe the birth attendants in the program area and approximately how many births per year are attended by each type: trained professional (nurse, midwife, or physician); trained traditional birth attendant; untrained traditional birth attendant; husband or other family member; self or other (specify).

Define the level of access (in terms of time, money, and available transportation) that the program considers "adequate" to allow women and their families in your area to promptly seek and use essential obstetric care. Estimate the percentage of the project beneficiary population that currently has access to essential obstetric care, and identify those areas/communities/groups which do not currently have adequate access. What are the main constraints to emergency obstetric services.

3. Knowledge and Practices

What are the barriers to prompt care-seeking for obstetric emergencies? What is the knowledge of women and families about danger signs that indicate the need for prompt care-seeking during pregnancy, labor and delivery, and post-partum.

What are the local words for danger signs recognized by community members as serious? What signs and symptoms of obstetric complications would lead women and families to seek outside help? From whom do women and families seek care for these

signs? Who makes the decisions in the household about when and from whom to seek care outside the home?

4. Approach

Which maternal/newborn care activities will the program implement?

Discuss the program's training curricula for each type of worker (TBA, clinic staff, community worker). Describe the group or groups that are being targeted for training by the program, and how the training of the targeted group addresses the essential elements of obstetric care.

If the program will be training personnel to deliver babies:

- (a) What curriculum will be used (PVO-designed, or that of another agency)?
- (b) Describe the components of the training program for obstetric first aid?
- (c) How will the birth attendant handle a complication or emergency? What is the chain of referral to get help, and what tool(s) will be used for assessing the need to refer? By whom will it be used?
- (d) Describe the immediate care of the newborn the birth attendant will be trained to give.

Describe activities that will be undertaken to assure the technical, financial, and organizational sustainability of the selected activities.

How will the maternal and newborn care intervention be linked to government policies and programs? Describe the relationship between approaches implemented through community-based workers, and those carried out by clinic-based practitioners. Describe and/or attach the program's documentation method for the maternal care intervention.

Describe how the program intends to develop a relationship with the referral facilities to improve the quality of maternal care services, and to accept women with obstetric emergencies? How will the program monitor the quality of services provided?

Describe how the program will improve access of the beneficiary population to facilities providing quality emergency obstetric care. Estimate the percentage of the beneficiary population that will have adequate access to an emergency obstetric care facility by the end of the project.

Does the program intend to provide postpartum care services? Describe how the program will provide education for postpartum women. Will community health workers make postpartum visits? How, when, and by whom, will program identify and address post-partum problems?

5. IEC

Describe your plans for information, education, and communication for maternal and newborn care. Define your behavior change objectives and groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on knowledge and practices? Briefly list the key messages the program plans to convey to the population. What IEC materials are available for use by families and by service providers?

Programs implementing a child spacing intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. MOH Policies, Current Services, Knowledge and Practices

Briefly describe the national family planning policies and program.

What information exists concerning family planning in the program area? What percent of mothers in the program site who do not want another child in the next two years, or are not sure, are using a modern contraceptive method? Include estimates of contraceptive prevalence, drop-out rates, and unmet need (and discuss the source of information).

Describe the services and facilities currently available in the program area, including the number and types of trained providers, the current commodity supply, distribution and storage system, and available counseling and referral systems. What group or groups are currently providing contraceptive services in the area? What family planning methods are currently accessible to women in the program area? Are contraceptive commodities easily available? Describe the current mechanism for obtaining contraceptives for women wishing to use them.

What are the main constraints to family planning? Describe constraints to: (1) maintaining a supply of contraceptive commodities, (2) educating women and men about family planning, (3) making contraceptives easily available, and (4) acceptance of contraceptives and acceptability of available services.

What are the perceptions of both users and non-users of currently available services (discuss the sources of this information)? What do community members (mothers, fathers, adolescents, elders) think about the current quality of child spacing services in the area?

2. Approach

Which of the following family planning activities will the program implement?

(a) Client identification - identifying men and women who desire family planning services. Describe who will do the identification, how they will be trained, and what will be the next step for the couple, once identified.

(b) Commodity Management - distributing family planning commodities. Describe what commodities will be made available, how they will be distributed, at what cost they will be made available to users, how the procurement of the contraceptives by

CHILD SPACING

the couple will be guaranteed over time, and how a constant supply of family planning commodities will be maintained.

(c) Training - attach the program's family planning training curricula for each type of worker (CBD, TBA, clinic staff, community worker).

(d) IEC - describe your plans for information, education, and communication for child spacing and family planning. Define your behavior change objectives and groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on knowledge and practices? Briefly list the key child spacing messages the program plans to convey to the population. What IEC materials are available for use by clients and by service providers?

(e) Quality Improvement - for both temporary and permanent methods, how will the quality of services be monitored and improved? What procedures will be used for infection prevention?

(f) Sustainability - describe efforts which will be undertaken to assure the technical, financial and organizational sustainability of the selected activities.

How will the family planning intervention be linked to government family planning policies and programs? Describe the relationship between approaches implemented through community-based workers, and those carried out by clinic-based practitioners. Describe and/or attach the program's documentation method for the family planning intervention.

Programs implementing an STI/HIV/AIDS intervention should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. Baseline information

What is the approximate prevalence and trend of HIV infection in the adult population in the program area and/or in other similar areas and populations of the country? Cite sources. If known, state the approximate prevalences of other STIs in the program area or region. What is the prevalence of positive syphilis serologies (blood tests) among women or among pregnant women in the program area?

Describe the relevant knowledge, beliefs, attitudes, and practices of adolescent and adult women and men in the program area related to the transmission and prevention of HIV infection. Include attitudes toward male and female fidelity, fertility, and family planning, and attitudes towards other STIs and regarding tuberculosis, if known.

What are the key factors that facilitate, or could facilitate, the spread of HIV infection in the program community? Describe the relevant findings from the HIV/AIDS portions of the baseline assessments.

2. MOH Policies and current activities in area

Briefly describe national policy and programs related to HIV/AIDS, including mandatory reporting regulations, and the confidentiality of sero-status. Describe or attach the national guidelines for the diagnosis and treatment of STIs, including regulations regarding partner notification and contact tracing.

What reproductive health services, including diagnostic services and supplies for treatment of STIs, are available in the area? What is the prevalence of modern contraceptive use? Describe condom supply and availability, including kinds of outlets and cost. Describe any activities related to HIV/AIDS prevention, care, and support that are currently under way (by any group) in the program area.

3. Experience and Constraints

What is the experience of program staff in HIV/AIDS-related activities? What existing activities or skills of program staff, if any, will facilitate including an intervention for HIV/AIDS in the program? If the HIV/AIDS intervention is a new activity for them, what do program staff feel will be the effect of implementing an HIV/AIDS-related intervention on how the child survival program is perceived in the community? If negative

community perceptions are anticipated, then what de-stigmatization strategies are planned?

What do staff feel to be the main obstacles to carrying out an effective STI/HIV/AIDS intervention in the program area? How will the program address the obstacles to the successful implementation of STI/HIV/AIDS activities?

4. Approach

Describe the HIV/AIDS component of the program. Include the general strategies that will be used, and describe the activities that will be carried out for the prevention, diagnosis, and counselling for HIV/AIDS, and approach for STI prevention and treatment. What activities will be conducted with families whose members are already infected with HIV? Who will the program train to provide HIV/AIDS prevention, care, and/or support services?

5. IEC

Describe your plans for information, education, and communication for HIV/AIDS prevention, care, and/or support. Define your behavior change objectives and groups to be targeted. Describe the IEC activities to be conducted, who will do the IEC, when it will be done, in what setting, and how often it will be done. How will the program develop and test IEC messages and materials, monitor the quality of the communications effort, and its impact on knowledge and practices? Briefly list the key messages the program plans to convey to the target population.

Programs implementing or supporting an IMCI strategy should address all of the following issues in their DIP, or explain why an issue is not relevant to the program. If the program has not yet obtained sufficient information to answer a question, then please indicate when and how you plan to obtain this information.

1. MOH strategies, activities, and training materials

Please describe in detail, or attach, the IMCI strategy of the MOH. Which elements of the case management/health facility staff skills component of IMCI (case management for diarrhea, ARI, malaria, etc.) are part of the national strategy? Which elements of the health systems strengthening component, and of the family and community practices component, are part of the MOH IMCI strategy?

At what stage in the process of adaptation and implementation of IMCI is the MOH's national IMCI effort? What IMCI-related activities have been conducted in the child survival program site to date, and what is the MOH schedule for IMCI implementation in the program site over the next three years? Which types of health facility staff and other health workers in the program site have been trained in IMCI, and what is the schedule for health worker IMCI training over the next three years?

Describe the IMCI training and other materials that the MOH is using for each component of IMCI.

2. Role of the child survival program in IMCI

Please describe in detail the role of the child survival program in IMCI, and the relationship between the program and MOH IMCI activities in the program area. Which elements of the case management/health facility staff skills component of IMCI (case management for diarrhea, ARI, malaria, etc.) will the child survival program support? Which elements of the health systems strengthening component, and of the family and community practices component, will the child survival program be involved with?

Attach in an annex a copy of the jointly signed agreement between the PVO/child survival program and the MOH/district health office which clearly identifies the roles and responsibilities of the program with regard to IMCI.

3. Specific components of the child survival program's IMCI strategy

For each component of IMCI which the child survival program will implement or support, please address the issues in the relevant sections of this document in your DIP. (For example, if your IMCI strategy includes ARI, then please address the issues

of the "Pneumonia Case Management" section of this document in your DIP, and do the same with regard to diarrhea/CDD, malaria case management, insecticide treated bednets, etc.)

If your IMCI strategy includes an important component which is not covered in these guidelines, then please describe your plans for implementing this component in detail, and discuss how the component relates to the WHO/UNICEF IMCI algorithm and training materials.

P. Technical Assistance Plan

- ◆ Briefly describe the qualifications and experience of key PVO headquarters, country, and program site staff with regard to each of the program's child survival interventions. If staff lack experience with any intervention, describe how intervention-specific knowledge and skills will be increased. If the program plans to obtain technical assistance for specific interventions or other components of the program, state the source and schedule of technical assistance, as currently planned.

ANNEXES

- I. Report of baseline assessments, including description of methods, and copies of questionnaires and other tools.
- II. Agreements with other organizations.
- III. Resumes/CVs of key PVO staff (if changed from application).
- IV. - Other annexes (as desired).

ANNEX D
RFA 938-99-A-0500-15
PVO CHILD SURVIVAL GRANTS PROGRAM

ANNEX D

USAID 22 CFR PART 226

BHR/PVC PVO CHILD SURVIVAL GRANTS PROGRAM

Available on Internet
(USAID Web Site Address:
<http://www.info.usaid.gov/pubs/ads/cfr22>)

ANNEX E
RFA 938-99-A-0500-15

PVO CHILD SURVIVAL GRANTS PROGRAM
ORGANIZATIONS REQUESTING FY 1999 CS RFA

	ORGANIZATION	ORGN. ACRONYM	ADDRESS	REQUESTOR	TEL/FAX/ E-MAIL
	Africare, Inc.	Africare	440 R. Street, NW Washington, D.C. 20001	Marguerite Joseph CS Project Manager	T: 202/462-3614 F: 202/387-1034 E: mjoseph@africare. org
	African Children Welfare Foundation	ACWF	2630 South Manhattan Place, Suite 1 Culver City, CA 90231	Dr. Marvin Iheonu	T: 213/735-6570 F:
	Applied Research & Development Institute International	ARDI	6740 East Hampden Ave., Suite 311 Denver, CO 80224	Anne Barrett	T: 303/691-6076 F: 303/691-6077 E: ardiintl@aol.com
	Armenian Fund U.S.A., Inc.	AFUSA	152 Madison Ave., Suite 803 New York, NY 10016	Mary Ann Kibarian Executive Director	T: 212/689-5307 F: 212/689-5317
	AVSC International	AVSC	79 Madison Avenue New York, NY 10016	Maynard Yost	T: 212/561-8067 F: 212/779-9439 E: myost@avsc.org
	Counterpart International	CI	1200 18th Street, NW., 11th Floor Washington, D.C. 20036	Darshana Vyas Sr. Public Health Specialist	T: 202/296-9676 F: 202/296-9679 E: info@counterpart. org

	ORGANIZATION	ORGN. ACRONYM	ADDRESS	REQUESTOR	TEL/FAX/ E-MAIL
	Concern Worldwide, Inc.	CWI	104 East 40th Street, Room 903 New York, NY 10016	Siobhan Walsh Executive Director	T: 212/557-8000 F: 212/557-8004
	Christian Children's Fund, Inc.	CCF	2821 Emerywood Parkway Richmond, VA 23261-6484	Mark Schomer Dir. Contracts/Gra nts	T: 804/756-2700 F: 804/756-2718 E: marks@ccfusa.org
	Federation of Jain Associations in North America	FJANA	135 Morningside Dr. Grand Island, NY 14072	Dr. Dhiraj H. Shah President	T: 716/775-0268
	Forging New Tomorrows, Inc.	FNT	1534 North Decatur Road, Suite 204 Atlanta, GA 30307	Dr. Marc Daniel GUTEKUNST Chairman & CEO	T: 404/636-5888 F: 404/321-5774
	Fund for Democracy and Development	FFDD	1101 15th St. NW, Suite 1004 Washington, D.C. 20005	Naya Kenman Project Officer	T: 202/296-5353 F: 202/296-5433 E: ffdd@erols.com
	Health Alliance International	HAI	1107 NE 45th Street, Suite 410 Seattle, WA 98105	Mary Anne Mercer	T: 206/543-8382 F: 206/685-4184 E:
	Health Volunteers Overseas	HVO	c/o Washington, Station P.O. Box 65157 Washington, D.C. 20035- 5157	Nancy Kelly Executive Director	T: 202/296-0928 F: 202/296-8018 E: hvo@aol.com
	Islamic African Relief Agency	IARA	P.O. Box 7084 Colombia, MO 65205	Elizabeth Miller Project Coordinator	T: 573/443-0166 F: 573/443-5975 E: iarausa@msn.com

	ORGANIZATION	ORGN. ACRONYM	ADDRESS	REQUESTOR	TEL/FAX/ E-MAIL
	International Institute of Rural Reconstruction	IIRR	475 Riverside Drive, Rm-1035 New York, NY 10115	Eric Blitz Director	T: 212/870-2992 F: 212/870-2981 E: iirr@nyxfer.blyth e.org
	INCLEN, Inc.	INCLEN	3600 Market Street, Suite 380 Philadelphia, PA 19104- 2644	Heather Sherman Program Asst.	T: 215/222-7700 F: 215/222-7741
	MAP International	MAP	P.O. Box 215000 Brunswick, GA 31521- 5000	Anna Dulany Int'l Program Coordinator	T: 912/265-6010 F: 912/265-6170 E: adulaney@map.org
	Maine Adoption Placement Service	MAPS	181 State St., P.O. Box 2249 Bangor, ME 04401	C. Huston	T: 207/941-9500 F: 207/941-8942 E: maps@bangornews.i nfi.net
	Minnesota International Health Volunteers	MIHV	122 West Franklin Ave., Suite 110 Minneapolis, MN 55404- 2480	Garth Osborn Director of Program	T: 612/871-3759 F: 612/871-8775 E: staff@mihv.org
	ORBIS International	ORBIS	330 West 42nd Street, Suite 1900 New York, NY 10036	Adam Zayan V. President of Progr.	T: 212/244-2525 F: 212/244-2744
	Save the Children	SC	54 Wilton Road (P.O. Box 950) Westport, CT 06881	Attn: Aurea Cruz Program Asst.	T: 203/221-4085 F: 203/221-3799 E: acruz@savechildre n.org

	ORGANIZATION	ORGN. ACRONYM	ADDRESS	REQUESTOR	TEL/FAX/ E-MAIL
	Wellstart International	WI	4062 First Avenue San Diego, CA 92103	Audry Naylor, MD President	T: 619/295-5197 F: 619/
	World Help	WH	P.O. Box 501 Forest, VA 24551	Noel Brewer Yeatts	T: 804/525-4657 X-120 F: 804/525-4727
	World Relief Corporation	WRC	P.O. Box WRC Wheaton, IL 60189	Olga Wollinka CS Grants Mananger	T: 630/665-0235 F: 630/665-4473
	World Vision Relief and Develop.	WVRD	220 I street, NE., Suite 270 Washington, D.C. 20002	Keirsten Giles	T: 202/547-3743 F: 202/543-0121 E: kgiles@worldvisio n.org

CURRENT AND PAST RECIPIENTS
PVO CHILD SURVIVAL GRANTS PROGRAM
(In Alphabetical Order)

ADRA	-	Adventist Development and Relief Agency
AFRICARE	-	Africare, Inc.
AKF	-	Aga Khan Foundation
AMREF	-	African Medical and Research Foundation
ARHC	-	Andean Rural Health Care
CARE	-	Cooperative for Assistance and Relief Everywhere
CCF	-	Christrian Children's Fund, Inc.
CRS	-	Catholic Relief Services
CWI	-	Concern Worldwide (U.S.), Inc.
CHILDSHOPE	-	ChildHope Foundation
CII (FSP)	-	Counterpart International, Inc
ESPERANCA	-	Esperanca, Inc.
ECI	-	Eye Care, inc.
FFH	-	Freedom from Hunger
FHI	-	Food for the Hungry International
FOCAS	-	Foundation of Compassionate American Samaritans
HAI	-	Health Alliance International
HKI	-	Helen Keller International
HOPE Inc.)	-	Project HOPE (The People-to-People Health Foundation,
IARA	-	Islamic African Relief Agency US Affiliate
ICC	-	International Child Care
IEF	-	International Eye foundation
LLI	-	La Leche League International
MCI	-	Mercy Corps International
MCDI	-	Medical Care Development International
MIHV	-	Minnesota International Health Volunteers
PATH	-	Program for Appropriate Technology in Health
PCI	-	Project Concern International
PFD	-	Partners For Development
PLAN	-	PLAN International USA, Inc (Childreach)
PSBF	-	The Pearl S. Buck Foundation, Inc
PSI	-	Population Services International
ROTARY	-	The Rotary Foundation of Rotary International
SAWSO	-	Savation Army World Services Office
SC	-	Save the Children Federation, Inc.
WRC	-	World Relief Corporation
WVRD	-	World Vision Relief and Development

ANNEX G

Office of Private and Voluntary
Cooperation

Bureau for Humanitarian Response

RESULT REVIEW
FY 1997

Available on the Internet

(USAID Web Site: http://www.info.usaid.gov/hum_response/pvc/pvcpubs.html)

MAY 19, 1998
BHR/PVC

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

CERTIFICATIONS, ASSURANCES, AND OTHER STATEMENTS OF APPLICANT/GRANTEE^{1 2}

1. ASSURANCE OF COMPLIANCE WITH LAWS AND REGULATIONS GOVERNING
NON-DISCRIMINATION IN FEDERALLY ASSISTED PROGRAMS

(a) The applicant/grantee hereby assures that no person in the United States shall, on the bases set forth below, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under, any program or activity receiving financial assistance from USAID, and that with respect to the grant for which application is being made, it will comply with the requirements of:

(1) Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352, 42 U.S.C. 2000-d), which prohibits discrimination on the basis of race, color or national origin, in programs and activities receiving Federal financial assistance;

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), which prohibits discrimination on the basis of handicap in programs and activities receiving Federal financial assistance;

(3) The Age Discrimination Act of 1975, as amended (Pub. L. 95-478), which prohibits discrimination based on age in the delivery of services and benefits supported with Federal funds;

(4) Title IX of the Education Amendments of 1972 (20 U.S.C. 1681, et seq.), which prohibits discrimination on the basis of sex in education programs and activities receiving Federal financial assistance (whether or not the programs or activities are offered or sponsored by an educational institution); and

(5) USAID regulations implementing the above nondiscrimination laws, set forth in Chapter II of Title 22 of the Code of Federal Regulations.

(b) If the applicant/grantee is an institution of higher education, the Assurances given herein extend to admission practices and to all other practices relating to the treatment of students or clients of the institution, or relating to the opportunity to participate in the provision of services or other benefits to such individuals, and shall be applicable to the entire institution unless the applicant/grantee establishes to the satisfaction of the USAID Administrator that the institution's practices in designated parts or programs of the institution will in no way affect its practices in the program of the institution for which financial assistance is sought, or the beneficiaries of, or participants in, such programs.

(c) This assurance is given in consideration of and for the purpose of obtaining any and all Federal grants, loans, contracts, property, discounts, or other Federal financial assistance extended after the date hereof to the applicant/grantee by the Agency, including installment payments after such date on account of applications for Federal financial assistance which were approved before such date. The applicant/grantee recognizes and agrees that such Federal financial assistance will be extended in reliance on the

¹ FORMATS/GRNTCERT: Rev. 04/04/95 (TM 13:63/TM 1B:90/CIB95-11)

² When these certifications, Assurances, and Other Statements of Applicant/Grantee are used for cooperative agreements, the following terms apply: "Grantee" means "Recipient," "Grant" means "Cooperative Agreement," and "Grant Officer" means "Agreement Officer."

representations and agreements made in this Assurance, and that the United States shall have the right to seek judicial enforcement of this Assurance. This Assurance is binding on the applicant/grantee, its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this Assurance on behalf of the applicant/grantee.

2.CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

(a)Instructions for Certification

(1)By signing and/or submitting this application or grant, the applicant/grantee is providing the certification set out below.

(2)The certification set out below is a material representation of fact upon which reliance was placed when the agency determined to award the grant. If it is later determined that the applicant/grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, the agency, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act.

(3)For applicants/grantees other than individuals, Alternate I applies.

(4)For applicants/grantees who are individuals, Alternate II applies.

(b)Certification Regarding Drug-Free Workplace Requirements

Alternate I

(1)The applicant/grantee certifies that it will provide a drug-free workplace by:

(A)Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the applicant's/grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(B)Establishing a drug-free awareness program to inform employees about--

1.The dangers of drug abuse in the workplace;

2.The applicant's/grantee's policy of maintaining a drug-free workplace;

3.Any available drug counseling, rehabilitation, and employee assistance programs; and

4.The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(C)Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (b)(1)(A);

(D)Notifying the employee in the statement required by paragraph (b)(1)(A) that, as a condition of employment under the grant, the employee will--

1.Abide by the terms of the statement; and

2.Notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five days after such conviction;

(E)Notifying the agency within ten days after receiving notice under subparagraph (b)(1)(D)1. from an employee or otherwise receiving actual notice of such conviction;

(F)Taking one of the following actions, within 30 days of receiving notice under subparagraph (b)(1)(D)2., with respect to any employee who is so convicted--

1.Taking appropriate personnel action against such an employee, up to and including termination; or

2.Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(G)Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (b)(1)(A), (b)(1)(B), (b)(1)(C), (b)(1)(D), (b)(1)(E) and (b)(1)(F).

(2)The applicant/grantee shall insert in the space provided below the site(s) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, state, zip code)

Alternate II

The applicant/grantee certifies that, as a condition of the grant, he or she will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

3.CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS -- PRIMARY COVERED TRANSACTIONS³

(a)Instructions for Certification

1.By signing and submitting this proposal, the prospective primary participant is providing the certification set out below.

2.The inability of a person to provide the certification required below will not necessarily result in denial of participation in this covered transaction. The prospective participant shall submit an explanation of why it cannot provide the certification set out below. The certification or explanation will be considered in connection with the department or agency's determination whether to enter into this transaction. However, failure of the prospective primary participant to furnish a certification or an explanation shall disqualify such person from participation in this transaction.

3.The certification in this clause is a material representation of fact upon which reliance was placed when the department or agency determined to enter into this transaction. If it is later determined that the prospective primary participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

4.The prospective primary participant shall provide immediate written notice to the department or agency to whom this proposal is submitted if at any time the prospective primary participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

³The applicant/grantee must obtain from each identified subgrantee and (sub)contractor, and submit with its application/proposal, the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion -- Lower Tier Transactions, set forth in Attachment A hereto. The applicant/grantee should reproduce additional copies as necessary.

5.The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meaning set out in the Definitions and Coverage sections of the rules implementing Executive Order 12549.⁴ You may contact the department or agency to which this proposal is being submitted for assistance in obtaining a copy of those regulations.

6.The prospective primary participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency entering into this transaction.

7.The prospective primary participant further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction,"⁵ provided by the department or agency entering into this covered transaction, without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

8.A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the methods and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Nonprocurement List.

9.Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealing.

10.Except for transactions authorized under paragraph 6 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency may terminate this transaction for cause or default.

(b)Certification Regarding Debarment, Suspension, and Other Responsibility Matters--Primary Covered Transactions

(1)The prospective primary participant certifies to the best of its knowledge and belief, the it and its principals:

(A)Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal department or agency;

(B)Have not within a three-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or

⁴See Chapter 3 of USAID Handbook 13, 22 CFR 208.

⁵For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the grant standard provision entitled "Debarment, Suspension, and Related Matters" if the applicant/grantee is a U.S. nongovernmental organization, or in the grant standard provision entitled "Debarment, Suspension, and Other Responsibility Matters" if the applicant/grantee is a non-U.S. nongovernmental organization.

performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(C)Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in paragraph (1)(B) of this certification;

(D)Have not within a three-year period preceding this application/proposal had one or more public transactions (Federal, State or local) terminated for cause or default.

(2)Where the prospective primary participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

4.CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1)No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement.

(2)If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions.

(3)The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, United States Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

5.AGREEMENT ON GRANT TERMS AND CONDITIONS

The applicant/grantee certifies that it has reviewed and is familiar with the proposed grant format and the standard provisions applicable thereto, and that it agrees to comply with all such terms and conditions, except as noted below (use a continuation page as necessary):

Solicitation No.

Application/Proposal No.

Date of Application/Proposal

Name of Applicant/Grantee

Typed Name and Title

Signature

Date

ENDRECORD

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Lower Tier Covered Transactions

(a) Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, has the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. 1/ You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier covered Transaction," 2/ without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the Non procurement List.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

1/See Chapter 3 of USAID Handbook 13, 22 CFR 208.

2/For USAID, this clause is entitled "Debarment, Suspension, Ineligibility, and Voluntary Exclusion (March 1989)" and is set forth in the USAID grant standard provision for U.S. nongovernmental organizations entitled "Debarment, Suspension, and Related Matters" (see Appendix 4C of USAID Handbook 13), or in the USAID grant standard provision for non-U.S. nongovernmental organizations entitled "Debarment, Suspension, and Other Responsibility Matters" (see Appendix 4D of USAID Handbook 13).

(b)Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transactions

(1)The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2)Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Solicitation No.

Application/Proposal No.

Date of Application/Proposal

Name of Applicant/Subgrantee

Typed Name and Title

Signature

Date